

Suicide Prevention

by Lynda Crawford
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Yobanna Genao was a 36-year old court reporter earning an impressive salary and raising three children on her own when, in 1997, she contracted a chronic illness that eventually made it impossible to work. She lost her job, her house, her car, her health insurance, and was forced to turn to public assistance. She began thinking of suicide.

This was not the first time in her life Genao had thought of killing herself. Suicidal thinking descended in her late teens, while attending college, after the death of a treasured aunt and the painful break-up of a relationship. Fortunately, a notice on a bulletin board at school about a counseling program caught her eye and she was able to get help. After a few weeks of therapy, the suicidal thoughts left, although it took months for the depression to entirely lift.

Her suicidal thoughts returned at the age of nineteen, when she was living at home with her mother who was herself depressed and threatening to kill herself if her daughter didn't stay with her. This time Genao did not seek help, but escaped the situation by getting married. Today she sees that decision as a symptom of the depression. "It was a bad choice," she said.

The marriage didn't work out. But Genao went back to school, got a better job, was given promotions, bought a house on Long Island for her and her children, and was graced with a positive attitude of just focusing on today, which helped her through the next fifteen years.

But the latest series of losses and financial strains have made for rough going. The depression returned, and so did the thoughts of suicide. "It's like when all the problems start coming at me at the same time I feel powerless, with no way out," she said, "and as I analyze the situation, it seems at times that everybody would be better off without me, especially my children... ."

A social worker referred Genao to a program for depression at the Payne Whitney Clinic. With the help of therapy, medication, and her therapist interceding on her behalf in matters relating to the physical illness (fibromyalgia), she has been able to counter the "naughty voice," as she calls it, that urges her to kill herself, with voices that offer reasons to live. For example, this voice says, her children need her.

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Before entering the program at Payne Whitney, Genao says she "looked like a bag lady. My life was a mess." Her daughter had been out of school for five months. Now she is back in school and has won many awards. Her 17-year old son is getting ready to go away to college and Genao has the clarity to be able to help him. Untreated though, "I didn't have the energy to deal with any of that."

"If you can treat the depression, you can prevent suicide," said Sue Matorin, former Director of Social Work, and now Treatment Coordinator for the Affective Disorder Team at the Payne Whitney Clinic of New York Presbyterian Hospital. "I've never seen anybody suicidal who wasn't severely depressed," said Ms. Matorin. "But depression is an illness that can be treated. There is something you can do about it."

Common roadblocks to treatment, however, are the stigma attached to having a mental illness, and the lack of coverage for treatment. People are ashamed to talk about depression or suicidal behaviors, and when they seek professional help, they often find their insurance won't cover mental health treatment in the same way it would a medical ailment.

"If you hear someone has leukemia," said Ms. Matorin, "you make a fund-raiser. But if the family didn't have enough money to treat depression, people are too embarrassed to mention it." Yet mentioning it, talking about it, is a crucial element in getting help. "Suicidal thinking has to do with feelings of hopelessness. If you get people to talk, you create arenas of hope. Different things can be done."

In the last year in which figures are available (1999) from the [Chief Medical Examiner](#), 494 people committed suicide in New York City, with the youngest age group listed as between 10 and 14, and continuing on up to ages 75 and above. These figures are down slightly from the previous year when 524 New Yorkers killed themselves. Men outnumbered women in every age group except 10 to 14, where the girls outnumbered the boys.

Suicide is the eighth leading cause of death in the United States (up from ninth in 1996) and the third leading cause of death for young people ages 15 to 24. More people die of suicide than homicide. In the last fifty years, suicide rates among adolescents have tripled.

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To deal with this crisis, Dr. David Satcher, the Surgeon General, recently outlined a [national strategy for suicide prevention](#) that includes:

- improving public awareness about who is at risk for suicide. The people who should know are health care, mental health and substance abuse workers, as well as educators, social workers, correction officers, clergy, divorce lawyers, family lawyers and criminal lawyers -- and the public at large
- implementing more suicide prevention programs in schools, colleges, jails, and the workplace
- reducing the stigma attached to suicidal thinking or depression that often discourages people from seeking help
- evaluating programs and increasing money, support and insurance coverage
- implementing these goals on a voluntary basis in each state by 2005.

"Suicide is a preventable problem," said Dr. Satcher at a news conference in May when he announced the plan. "We should make it clear that suicide prevention is everybody's business."

There are populations that have been found to be at special risk for suicide. These include teenagers, especially gay, lesbian, bisexual and transgender teens; the elderly, particularly elderly men; those who have experienced trauma (for example, veterans, and also victims of sexual assault or physical abuse); people with problems of depression, or mood disorders; those with drug or alcohol dependence; people in trouble with the law; those who have made previous suicide attempts; compulsive gamblers; and Native Americans.

One in ten college students considers suicide, according to recent data, and researchers at the [Centers for Disease Control and Prevention](#) find that college students have a 50 percent greater chance of suicidal behavior with alcohol or drug dependence. On the plus side, resources to help with depression are generally very good at colleges, if the students in need are steered towards them.

Suicide is the third leading cause of death in prisons, following natural causes and AIDS. The vast majority of these suicides occur among mentally ill prisoners, and over 50 percent within 24 hours of incarceration. Youth suicide in juvenile detention centers and correctional facilities is four times greater than the general population. Promising suicide prevention initiatives have begun in jails and prisons, but continuing suicides among newly committed mentally ill inmates suggests that more needs to be done.

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One successful suicide prevention program highlighted by the Surgeon General is the [U.S. Air Force program](#)

. Alarmed by the finding that one in four deaths of Air Force personnel was the result of suicide, the Air Force set up the program in 1996. An analysis of the suicides showed that the service men and women were more likely to kill themselves following a break-up with a spouse or if they were in trouble with military court. So they started a program to make everyone more aware of suicide warning signs and made it easier to get help. For example, one rule was changed so that Air Force personnel with legal problems can seek psychological counseling without worrying that anything they say can be used against them. In just three years, the Air Force cut its suicide rate by two-thirds. Other branches of the military had no program and their rates remained the same.

A local suicide prevention program, the Suicide Hotline (212-673-3000) run by the [Samaritans of New York](#)

receives over 100 calls a day, approximately 40,000 calls a year. Executive Director Alan Ross has been on the hotline for ten years now, starting as a volunteer himself. Although the number of daily calls has doubled in that time, the issues behind the calls, the feelings, he says, remain the same. "The issues are pretty universal," said Ross. "They haven't changed with time and they are the same whether you are in New York or Brazil or Sri Lanka: social isolation and feelings of hopelessness."

The main tool used by the all-volunteer staff is active listening, allowing the caller to bring feelings about suicide out into the open, without judgment, which can be a great relief. The Samaritans do not counsel. "It's pure support," said Ross. Occasionally they will make a referral.

Although they have a web page, the hotline does not have on-line access for help. "It's hard enough to run a 24-hour phone hotline" said Ross. But their web page does provide information on warning signs for suicide, and what to do if you or someone you know is feeling suicidal. They also run a program for survivors of suicide.

Ross was very upbeat about the Surgeon General's prevention strategy. "It is significant," said Ross. "It puts suicide on the national agenda. It acknowledges mental health as an issue, and depression as an illness."

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[The city](#) also has a 24-hour hotline called Lifenet (800/543-3638 or 800 LIFENET) and Lifenet en Espanol (877/298-3373 or 877 AYUDESE) which offers referrals to resources for mental health emergencies, including suicide, and alcohol and substance abuse. And the [American Association of Suicidology](#) has a 24-hour National Hopeline (800/SUICIDE).

A suicide prevention program in the city with a different focus is CARES (Children's Attitudes, Responses and Emotions to Suicide), a clinical and research program for children who have had a death in the family from suicide, most often a parent or sibling, but sometimes a grandparent. Developed and run by Dr. Cynthia Pfeffer, author of *The Suicidal Child* (Guilford Press, New York), CARES helps children, from infancy through late adolescence, understand the illness aspect of suicide, and that they were not purposely abandoned.

"Children who have had a suicide in the family are very high risk for suicide themselves or for psychiatric disorders such as depression and substance abuse," said Dr. Pfeffer "So this is very much a preventative program."

Significantly, Dr. Pfeffer explained, children who survive a suicide are faced not only with the stress and the stigma, but may also be having thoughts of joining the family members who committed suicide.

CARES is part of the [Childhood Bereavement Program](#) at Weill Medical College of Cornell University with offices at the Payne Whitney Clinic on East 68th Street (and in Westchester). Dr. Pfeffer also runs a program for adult survivors, and continues her work with children who are themselves suicidal.

Most people who attempt suicide do something to let people know their intentions, but too often these warning signs are ignored by family, friends, coworkers, teachers, and doctors. Warning signs for suicidal thinking include:

- talking about committing suicide
- trouble eating or sleeping
- drastic changes in behavior
- withdrawal from friends and social activities
- loss of interest in hobbies, work, school, etc.

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- giving away prized possessions
- previous suicide attempts
- taking unnecessary risks
- recent severe losses
- preoccupation with death and dying
- loss of interest in personal appearance
- increasing use of alcohol or drugs

If someone exhibits these warning signs, talk directly to them about it. Watch for statements like "nobody cares," or "everyone will be better off without me." Ask them if they are thinking of suicide, and if they say yes, ask if they have a plan. Get help from people or agencies specializing in crisis intervention and suicide prevention, such as a community mental health agency, private therapist, school counselor or psychologist, family physician or suicide prevention center.

And if you are feeling suicidal yourself? "Get help immediately," says Yobanna Genao. "Go to the nearest emergency room. Call somebody."