WHEN DEPRESSION TURNS FATAL:
RECOGNIZING THE RISKS OF SUICIDE AMONG LAWYERS
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"Suicide is not a blot on anyone's name; it is a tragedy."
Kay Redfield Jamison, Night Falls Fast: Understanding Suicide

First Things First: The question you never ask:

"You're not thinking about committing suicide or harming yourself, are you?"

It's the wrong question. When this form of the question is used, you are conveying to the distressed individual that you want or need them to answer "no." They are not invited to be truthful. **Don't ask the question this way.** Read on for instructions on how to be an effective helper to someone in crisis.

I. INTRODUCTION

The purpose of this program is to encourage and educate those who are suffering from anxiety and depression and who may be at risk for suicide, as well as to educate all Kentucky Bar members. We must acknowledge the severity of the problem here in Kentucky, and we must be willing and able to identify warning signs among our colleagues.

Kentucky is the third most depressed state in the country. Only two states have higher rates of depression than Kentucky: West Virginia at number two, and Utah at number one. (Mental Health America: Ranking America's Mental Health: An Analysis of Depression across the States). On average, people with depression go for nearly a decade before receiving treatment. *Id.* It is likely that lawyers go much longer without seeking help than the average person. Lawyers seem to have a greater amount of shame and so we perceive that because we help others, we must be able to help ourselves. Of course, this is a myth.

II. THE ROLE OF STRESS IN DEPRESSION

"Stress" may be defined as anything in our environment that knocks our bodies out of their homeostatic balance. The stress response is the physiological adaptations that ultimately reestablish balance. Recently, scientists have been focusing in on the connection between stress and anxiety and the role they play in producing and maintaining depression. For a high-stress profession like practicing law, this link is alarming and should cause great concern.

"If stress is chronic, repeated challenges may demand repeated bursts of vigilance. At some point the vigilance becomes overgeneralized leading us to conclude that we must always be on guard – even in the absence of stress. And thus the realm of anxiety is entered." Dr. Robert Sapolsky, *Lawyers with Depression, The Stress Depression Connection,* May 11, 2008, [www.lawyerswithdepression.com](http://www.lawyerswithdepression.com).
See if this description sounds familiar:

Stress went on too long in my own life as a litigator. I had, indeed, entered the realm of anxiety. For me, this anxiety felt like I had a coffee pot brewing twenty four-seven in my stomach. I became hypervigilant, each of the files on my desk felt like ticking time-bombs about to go off. Over time, the litigation mountain became harder to climb as the anxiety persisted over a period of years.

Dan, Lawyers with Depression

Unfortunately, if the chronic stress is (or even seems to be) insurmountable, it gives rise to helplessness. This helplessness may be so generalized that the person is unable to accomplish tasks they could actually master. Helplessness is a pillar of a depressive disorder. It becomes a major issue for lawyers because we aren't supposed to experience periods of helplessness.

Studies are showing that the presence of co-morbid anxiety disorders and major depression is very frequent and, according to some studies, as high as 60 percent. This may shed light on why the depression rates for lawyers are so much higher than for everyone else. We work in a chronically anxious and stressful state. Lawyer with Depression, The Stress Depression Connection, May 11, 2008, www.lawyerswithdepression.com.

Over time, this type of chronic anxiety causes the release of too much of the fight-or-flight hormones, cortisol and adrenaline. Research shows clearly that prolonged release of cortisol damages areas of the brain that have been implicated in depression, the hippocampus (involved in learning and memory), and the amygdala (involved in how we perceive fear). Id.

III. MANIFESTATION OF SEVERE DEPRESSION IN LAWYERS AND ETHICAL CONCERNS

There are very few studies of lawyer impairment and its impact on ethical breaches, and this is so for a couple of reasons. First, much of lawyer impairment is hidden, and the client never knows there is an impairment or that there even is an ethical breach (i.e., the client generally has no idea whether the lawyer is filing pleadings timely). Second, disciplinary counsels of most state boards typically don't keep records of the relationship of mental health impairment to ethical violations, and so it is not reported in any usable statistical form. There are, however, some general statistics. For example, a study of discipline cases in Ontario, Canada, revealed that nearly 50 percent of lawyers facing serious disciplinary sanctions there have admitted to either alcohol, drug or psychiatric impairment. Legal Profession Assistance Conference, "Addiction and Psychiatric Impairment of Lawyers and Judges; A Search for Meaningful Data." Discipline Digest, LSUC, October 1992 - October 1995.

The American Bar Association's former Commission on Impaired Attorneys (now the Commission on Lawyer Assistance Programs) has suggested that as many as 90 percent of all serious trust fund disciplinary matters involve severe mental health issues and/or substance abuse, primarily alcoholism.
The areas in which Kentucky and other bar associations see the highest level of complaints are not coincidentally the three areas in which the severely depressed or impaired attorney will have the greatest struggle. Refer to the identifying traits, supra. Specifically: communication, competency and diligence.

Pursuant to Supreme Court Rule 3.130(1.4) Communication:

(a) A lawyer should keep a client reasonably informed about the status of a matter and promptly comply with reasonable request for information.

(b) A lawyer should explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

Pursuant to Supreme Court Rule 3.130(1.1) Competence:

A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

Comments: Thoroughness and Preparation

[5] Competent handling of a particular matter includes inquiry into and analysis of the factual and legal elements of the problem, and use of methods and procedures meeting the standards of competent practitioners. It also includes adequate preparation. The required attention and preparation are determined in part by what is at stake; major litigation and complex transactions ordinarily require more elaborate treatment than matters of lesser consequence.

Maintaining Competence

[6] To maintain the requisite knowledge and skill, a lawyer should engage in continuing study and education. If a system of peer review has been established, the lawyer should consider making use of it in appropriate circumstances.

And, pursuant to Supreme Court Rule 3.130 (1.3) Diligence:

A lawyer shall act with reasonable diligence and promptness in representing a client.

Each of these requirements - communication, competency and diligence - become harder and harder for the depressed attorney to complete or maintain as the depressive illness progresses. Hence, hopelessness begins to set in. The more difficult the circumstance, the more likely that attorney's thoughts may turn to suicide and escape.
IV. SUICIDE WITHIN THE PRACTICE OF LAW

As set forth herein, risk factors for suicide include depression, anxiety, substance abuse, divorce and stress. Lawyers experience ALL of these risk factors at a higher rate than the general population. Lawyers are also more likely to be perfectionists and competitive - personality traits which make a person considering suicide less likely to seek help. Larry Berman, Executive Director, American Association of Suicidology.

As stated by Robin Frazer Clark, Georgia Bar President, in her President's Page of the Georgia Bar Journal, December, 2012, "[F]ailure is not an option in a high-stakes profession such as ours. As a result, lawyers are three times as likely to suffer depression as any other profession . . . ."

The natural progression of depression, when untreated, is suicide.

Lest there be any doubt, if left untreated, depression can be fatal. In an eighteen month period, at least nine members of our Kentucky bar died by suicide.

Sadly, these were deaths that were almost completely preventable had the signs been clear or recognized. Unfortunately, many times we, as lawyers, have gotten so good at hiding our true feelings and repressing our actual emotions (skills which are not only useful, but imperative if we are to be effective advocates for our clients), that it is nearly impossible - even for our loved ones - to understand or recognize the symptoms. No one is to blame. We only have an obligation to act when we know the signs of which to be aware. That being said, acknowledging that we, as lawyers, may be masters of repressing our true feelings, means that we must be hyper-vigilant with our colleagues. After we have been educated, we are responsible. There is a duty to help your colleagues when you see the signs that may be preceding an attempted suicide. It is better to be safe than sorry. It is better to have courage than regret.

Thoughts of suicide are not the distressed individual's problem. They are the distressed individual's perceived solution to the real problem or problems. Suicide has been called "a permanent solution to a temporary problem." Our obligation is to recognize when someone is anticipating or seriously considering this "final solution" and guide them in the direction of real solutions and help. When the mental health issues that may lead to suicide are recognized early, experts agree that suicide is almost entirely preventable.

It is tempting when looking at the life of anyone who has committed suicide to read into the decision to die a vastly complex web of reasons; and, of course, such complexity is warranted. No one illness or event causes suicide; and certainly no one knows all, or perhaps even most, of the motivations behind the killing of the self. But psychopathology is almost always there, and its deadliness is fierce. Love, success and friendship are not always enough to counter the pain and destructiveness of severe mental illness.

Kay Redfield Jamison, Night Falls Fast: Understanding Suicide
V. GENERAL POPULATION STATISTICS

Suicide is the eleventh leading cause of death among all Americans. (Anderson & Smith, 2003), the second leading cause of death among Americans ages 25-34, and the third leading cause of death among Americans ages 10 to 14 and 15 to 24 (Centers for Disease Controls, 2005). Annual death certificates in the US suggest that over 30,000 persons commit suicide each year. (National Center for Health Statistics, 2006).

Approximately eighty-nine persons in the United States commit suicide every day (McIntosh, 2006). This equates to nearly four suicides each hour, or one suicide every sixteen minutes (McIntosh, 2006).

In Kentucky, the general population facts about suicides are as follows:

A. Kentucky loses three times as many citizens to suicide each year as to homicide.

B. There is an average of 5.7 suicide attempts every day in Kentucky.

C. Kentucky's suicide death rate in 2009 was the twenty-third highest in the nation (down from tenth in 2007).

D. Suicide is the second leading cause of death for Kentuckians ages fifteen to thirty-four years old.

E. Suicide is the fourth leading cause of death for adults ages thirty-five to forty-four years old.

F. Our elderly have a higher suicide rate than the national average.

G. Firearms caused 62 percent of suicide deaths in Kentucky.

H. During 2006 in Kentucky, 2,088 suicide attempts were serious enough to warrant admission to a hospital.

I. Two out of three Kentuckians (64 percent) know at least one person who has attempted or died by suicide.

J. One out of three (33.8 percent) consider themselves to be a suicide survivor (someone who has lost a loved one or close friend to suicide).

K. Experts believe most suicidal people don't want to die, they just want to end their pain. When suicidal behaviors are detected early, lives can be saved.

Citation: www.kentuckysuicideprevention.org

In the United States, the suicide rate in the general population is 11.79 per 100,000 deaths. In Kentucky, the rate is 13.44 suicides per 100,000 deaths.
That is, Kentucky's overall rate of suicide is 14 percent higher than the national average.

VI. LAWYER STATISTICS VERSUS GENERAL POPULATION

As compared to eleven deaths by suicide for each 100,000 deaths in the general population, the national average rate for lawyers is sixty-six suicides per 100,000 deaths. Lawyers are more than six times more likely than the general population, to commit suicide (National Institute of Mental Health). If we raise that number by 14 percent to reflect Kentucky's higher general rate, our suicide rate is 75 deaths of lawyers by suicide per 100,000 deaths. That is far too great a loss.

In a 2015 ABA/HazeldenBettyFord national study, 11.5 percent of the attorneys responding reported suicidal thoughts at some point during their career, 2.9 percent reported self-injurious behaviors, and 0.7 percent reported at least 1 prior suicide attempt.

Male lawyers between the ages of 20 and 64 are more than twice as likely to die from suicide as men of the same age in other occupations. National Institute for Safety and Health Study.

Suicide was the third leading cause of death among lawyers insured by the Canadian Bar Insurance Association. (It's the tenth leading cause of death in US in general). Canadian Bar Association Study.

Unfortunately, these shockingly high suicide numbers set forth above may inaccurately reflect the real numbers and real impact of US suicides. (Granello & Granello, 2007; Granello & Juhnke, in press). This is because suicide data is based on causes of death as reported on death certificates only. Given that many suicides are likely misreported - not as suicides, but as automobile accidents, hunting accidents, swimming accidents, or accidental alcohol or drug overdoses - the true suicide number is most likely significantly higher. (Juhnke, Granello & Lebron-Striker, Professional Counseling Digest, 2007).

"If they tell you that she died of sleeping pills, you must know that she died of a wasting grief, of a slow bleeding at the soul."  
Clifford Odets

Not insignificantly, the current suicide rates fail to address the number of failed suicide attempts. Since there is no standardized method of data collection among doctors or hospitals related to suicide attempts, there is no hard data to reflect these numbers. However, the American Association of Suicidology (2006) has estimated that at least 25 suicide attempts occur for each completed suicide. (Juhnke, Granello & Lebron-Striker, supra). Based on this number, it is suggested that approximately 811,000 persons in the US made unsuccessful suicide attempts in 2004. This equates to one suicide attempt every 39 seconds (McIntosh, 2006).
VII. RISK FACTORS FOR SUICIDE

A. Psychiatric Disorders

At least 90 percent of people who take their own lives have a diagnosable and treatable psychiatric illnesses - such as major depression, bipolar disorder, or some other depressive illness, including:

1. Schizophrenia.
2. Alcohol or drug abuse, particularly when combined with depression.
3. Post-traumatic Stress Disorder, or some other anxiety disorder.
4. Bulimia or anorexia nervosa.
5. Personality disorders especially borderline or antisocial (and lawyers are at a higher risk for antisocial behavior than the general population, too).

B. Past History of Attempted Suicide

Between 20 and 50 percent of people who kill themselves have previously attempted suicide. Those who have made serious suicide attempts are at a much higher risk for actually taking their own lives.

C. Genetic Predisposition

Family history of suicide, suicide attempts, depression or other psychiatric illness.

D. Neurotransmitters

A clear relationship has been demonstrated between low concentrations of the serotonin metabolite 5-hydroxyindoleactic acid (5-HIAA) in cerebrospinal fluid and an increased incidence of attempted and completed suicide in psychiatric patients.

E. Impulsivity

Impulsive individuals are more apt to act on suicidal impulses.

F. Demographics

1. Sex: Males are three to five times more likely to die by suicide than females.
2. Age: Elderly Caucasian males have the highest suicide rates.
VIII. WARNING SIGNS OF A SUICIDE RISK

Suicide can be prevented. While some suicides occur without any outward warning, most people who are suicidal do give advance warnings. You may be able to reduce the likelihood of suicide by loved ones by learning to recognize the signs of someone at risk, taking those signs seriously, and then knowing how to respond to them.

General Warning Signs of Suicide Include:

A. Observable signs of serious depression:
   1. Unrelenting low mood.
   2. Pessimism.
   3. Hopelessness.
   4. Desperation.
   5. Signs of Anxiety (including panic, insomnia and agitation).
   6. Withdrawal from usual activities or loved ones.
   7. Sleep problems.

B. Increased alcohol and/or other drug use

C. Recent impulsiveness and taking unnecessary risks, reckless behavior

D. Threatening suicide or expressing a strong wish to die

E. Making a plan:
   1. Giving away prized possessions.
   2. Sudden or impulsive purchase of a firearm.
   3. Obtaining other means of killing oneself such as poisons or medications.

F. Unexpected rage or anger or any other dramatic mood change

Larry Berman, Executive Director, American Society of Suicidology, supra.

The emotional crisis (or crises) that usually precede suicide is often recognizable and treatable. Although most depressed people are not suicidal, most suicidal people are depressed. Serious depression can be manifested in obvious sadness but often it is rather expressed as a loss of pleasure or withdrawal from activities that had been enjoyable. One can help prevent suicide through early recognition and treatment of depression and other psychiatric illnesses.
IX. OTHER INDICATORS THAT SOMEONE MAY TAKE THEIR LIFE

Most suicidal individuals give some warning of their intentions. But there may be less obvious signs. The most effective way to prevent a friend or loved one from taking his or her life is to recognize the factors that put people at risk for suicide. Take warning signs seriously and know how to respond. Don't be afraid to talk about it. There is too much at stake to avoid these early warning signs.

Know the Facts:

A. Psychiatric Disorders

More than 90 percent of people who commit suicide are suffering from one or more psychiatric disorders, in particular:

1. Major depression (especially when combined with alcohol and/or drug abuse);
2. Bipolar disorder;
3. Alcohol abuse and dependence;
4. Drug abuse and dependence;
5. Schizophrenia;
6. Post-Traumatic Stress Disorder (PTSD);
7. Eating disorders;
8. Personality disorders.

Depression and the other mental disorders that may lead to suicide are - in most cases - both recognizable and treatable.

The core symptoms of major depression are a "down" or depressed mood most of the day or a loss of interest or pleasure in activities that were previously enjoyed for at least two weeks, as well as:

- Changes in sleeping patterns;
- Change in appetite or weight;
- Intense anxiety, agitation, restlessness or being slowed down;
- Fatigue or loss of energy;
- Decreased concentration, indecisiveness or poorer memory;
• Feelings of hopelessness, worthlessness, self-reproach or excessive or inappropriate guilt; and

• Recurrent thoughts of death or suicide.

B. Past Suicide Attempts

Between 25 and 50 percent of people who kill themselves had previously attempted suicide. Those who have made suicide attempts are at higher risk for actually taking their own lives.

C. Availability of means

In the presence of depression and other risk factors, ready access to guns and other weapons, medications or other methods of self-harm increases suicide risk.

D. Recognize the Imminent Dangers

E. The signs that most directly warn of suicide include:

1. Threatening to hurt or kill oneself;
2. Looking for ways to kill oneself (weapons, pills or other means);
3. Talking or writing about death, dying or suicide; and
4. Has made plans or preparations for a potentially serious attempt.

F. Other warning signs include expressions or other indications of certain intense feelings in addition to depression, in particular:

1. Insomnia;
2. Intense anxiety, usually exhibited as psychic pain or internal tension, as well as panic attacks;
3. Feeling desperate or trapped -- like there's no way out;
4. Feeling hopeless;
5. Feeling there’s no reason or purpose to live;
6. Rage or anger.

G. Certain behaviors can also serve as warning signs, particularly when they are not characteristic of the person's normal behavior. These include:

1. Acting reckless or engaging in risky activities;
2. Engaging in violent or self-destructive behavior;
3. Increasing alcohol or drug use;
4. Withdrawing from friends or family.

H. Take it Seriously
1. Fifty to 75 percent of all suicides give some warning of their intentions to a friend or family member.
2. Imminent signs must be taken seriously.

I. Be Willing to Listen
1. Start by telling the person you are concerned and give him/her examples.
2. If he/she is depressed, don't be afraid to ask whether he/she is considering suicide or if he/she has a particular plan or method in mind.
3. Ask if they have a therapist and are taking medication.
4. Do not attempt to argue someone out of suicide. Rather, let the person know you care, that he/she is not alone, that suicidal feelings are temporary and that depression can be treated. Avoid the temptation to say, "You have so much to live for," or "Your suicide will hurt your family."

J. Seek Professional Help
1. Be actively involved in encouraging the person to see a physician or mental health professional immediately.
2. Individuals contemplating suicide often don't believe they can be helped, so you may have to do more.
3. Help the person find a knowledgeable mental health professional or a reputable treatment facility, and take them to the treatment.

X. WHAT IS A SUICIDE CRISIS?

A “suicide crisis” is a time-limited occurrence signaling immediate danger of suicide. This is as opposed to a "suicide risk" (discussed above), which is the broader term that includes the above factors such as age and sex, psychiatric diagnosis, past suicide attempts, and traits like impulsivity.
The signs of crisis (again, immediate danger) are:

A. Precipitating Event

A recent event that is particularly distressing such as loss of loved one or career failure. Sometimes the individual's own behavior precipitates the event: for example, a man's abusive behavior while drinking causes his wife to leave him.

B. Intense Affective State in Addition to Depression

Desperation (anguish plus urgency regarding need for relief), rage, psychic pain or inner tension, anxiety, guilt, hopelessness, acute sense of abandonment.

C. Changes in Behavior

1. **Speech** suggesting the individual is close to suicide. Such speech may be indirect. Be alert to such statements as, "My family would be better off without me." Sometimes those contemplating suicide talk as if they are saying goodbye or going away.

2. **Actions** ranging from buying a gun to suddenly putting one's affairs in order.

3. **Deterioration in functioning** at work or socially, increasing use of alcohol, other self-destructive behavior, loss of control, or rage explosions.

XI. WHAT TO DO IN AN ACUTE CRISIS

A. If a friend or loved one is threatening, talking about, or making plans for suicide, these are signs of an acute crisis.

1. Do not leave the person alone.

2. Remove all alcohol from the person and/or the home.

3. Remove from the vicinity any firearms, drugs or sharp objects that could be used for suicide.

4. Take the person to an emergency room or walk-in clinic at a psychiatric hospital.

5. If a psychiatric facility is unavailable, go to your nearest hospital or clinic.

6. If the above options are unavailable, call 911 or the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or 1-800-SUICIDE.
B. Follow-up on Treatment

Suicidal individuals are often hesitant to seek help and may need your continuing support to pursue treatment after an initial contact.

If medication is prescribed, make sure your friend or loved one is taking it exactly as prescribed. Be aware of possible side effects and be sure to notify the physician if the person seems to be getting worse. Usually, alternative medications can be prescribed.

Frequently, the first medication doesn't work. It takes time and persistence to find the right medication(s) and therapist for the individual person. Encourage the individual to "keep trying."

XII. CONCLUSION - IN A NUTSHELL:

What to do if You Notice Someone (of any age) Exhibiting Signs of Suicide Risk:

A. Open a dialogue. Asking questions will help you to determine if the person is in immediate danger. Always take thoughts of, or plans for, suicide seriously.

1. AGAIN: The question you NEVER ask:

"You're not thinking about committing suicide, are you?"

This question tells the person you want them to say "no." It's the wrong form.

2. Be direct. Talk openly and matter-of-factly about suicide. Ask, "Do you ever feel so badly that you think about suicide?" or "Do you have a plan to commit suicide or take your life?"

3. Be willing to listen. Allow expressions of feelings.

4. Be non-judgmental. Don't debate whether suicide is right or wrong, or whether feelings are good or bad. Lecturing (for example, on the value of life) or being shocked will put distance between you.

5. Be available. Show interest and support.

6. Offer hope that alternatives are available.

7. Take action.

B. Do not leave the person alone, if you think they might harm him or herself, until the next steps are accomplished.

C. Let them know you are going to do what you can to help them.
D. While they are with you, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or 1-800-SUICIDE to be connected to the nearest available crisis center for a referral to local mental health resources.

E. If the person at risk is a colleague, you should similarly call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) OR 1-800-SUICIDE and also refer the colleague to KYLAP at 1-502-564-3795.
STATE OF KENTUCKY – SUICIDE RESOURCES AND SUPPORT GROUPS

Kentucky suicide prevention group:  www.kentuckysuicideprevention.org

Kentucky Suicide Prevention Group
1603 Vivian Lane
Louisville, KY 40205
TELEPHONE:  (502) 931-3999

Jan Ulrich
State Suicide Prevention Coordinator
Kentucky Dept for Behavioral Health, Developmental and Intellectual Disabilities
100 Fair Oaks Lane, 4E-D
Frankfort, KY 40621
Email: jan.ulrich@ky.gov
TELEPHONE:  (502) 564-4456  Ext: 4436
SUICIDE AMONG TEENS -- Frequently Asked Questions

There is also a growing number of teens and young adults who attempt suicide. To address these issues, here are some frequently asked questions. Many of these questions came from young teens struggling to understand the suicide attempts of friends, and trying to learn how they can help.

1. What percentage of college students who kill themselves are male? Why do you think more/less boys than girls kill themselves?

   Seventy-five to 80 percent are boys although more girls attempt suicide. Boys are more involved than girls in all forms of aggressive and violent behavior.

2. I've heard that suicides are more frequent around the holidays? Is this true, and if so, how much do they increase at that time?

   Suicides are not more frequent during the holidays. It appears that the rates are the highest in April, and the summer months, June and July.

3. It is often said that a suicidal person goes through a period where he seeks help from other people. Does this then mean that it could be ultimately the fault of other people (because they don't appear concerned enough) that one decides to kill him/herself?

   Not a fair conclusion, although it could be a contributing factor in some cases particularly with elderly, terminally ill people.

4. What is the biggest cause of suicide among college students?

   Ninety-five percent are suffering from mental illness, usually depression. If depressed, substance abuse, anxiety, impulsivity, rage, hopelessness and desperation increase the risk.

5. Apart from talking to a suicidal person and encouraging him/her to go for counseling, what else can we do to prevent this?

   Going with someone to the counselor often helps. If the person won't listen to you, you may need to talk to someone who might influence him or her. Saving a life is more important than violating a confidence.

6. People often get uncomfortable when one discloses something as intimate and frightening as suicidal thoughts. What do you think can be done to reduce this stigma, either of suicidal people, or of depressive patients? Can people actually "change" their minds and accept someone who is suicidal?

   As people recognize that suicidal behavior is the result of a medical condition not a sign of weakness or character defect it will change.
7. What is the most frequent method of suicide? Is the most frequent method different for men and women?

Fifty-two percent of all people who kill themselves do so with a firearm, accounting for almost 17,000 deaths each year in the United States. Use of a firearm is the number one method in those aged 35 and up.