Office of Suicide and Violence Prevention

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Lethal Means Safety and Adult Mental Health

In this Issue...

Let's Make a Difference Together

988 SUICIDE & CRISIS LIFELINE

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Support from trained counselors is available 24/7!

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https://988lifeline.org/es/servicios-en-espanol/

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SVP Events & Highlights

9/12/2023: Dr. Poland was the presenter at a Mental Health Townhall sponsored by Florida State Representative, Christine Hunshofsky and held at the Coconut Creek City Hall.

9/13/2023: Dr. Poland and Dr. Hubbard provided a university wide training session at the Alvin Sherman library on suicide prevention.

9/13/2023: Dr. Poland provided a virtual presentation on suicide prevention sponsored by Broward County United Way.

10/5/2023: Dr. Poland provided a virtual presentation on suicide prevention for the Maryland Governor's Suicide Prevention Commission.

10/5/2023: First Year Experience Suicide Prevention presentation at NSU medical school.

10/29/2023: Out of the Darkness Walk at NSU. Dr. Poland gave the opening speech.

11/1/2023 - Dr. Poland and Dr. Hubbard presented the Florida School Toolkit for K-12 Eductors to Prevent Suicide (STEPS) at FASP.

11/6/2023 - 11/7/2023: Dr. Poland led workshops on "Youth Suicide: Prevention, Intervention and Postvention for Schools" at the International School Counselor Association Virtual Collaborative online conference.

11/8/2023 - Dr. Poland and Dr. Hubbard presented at Broward College's Mental Health Symposium.

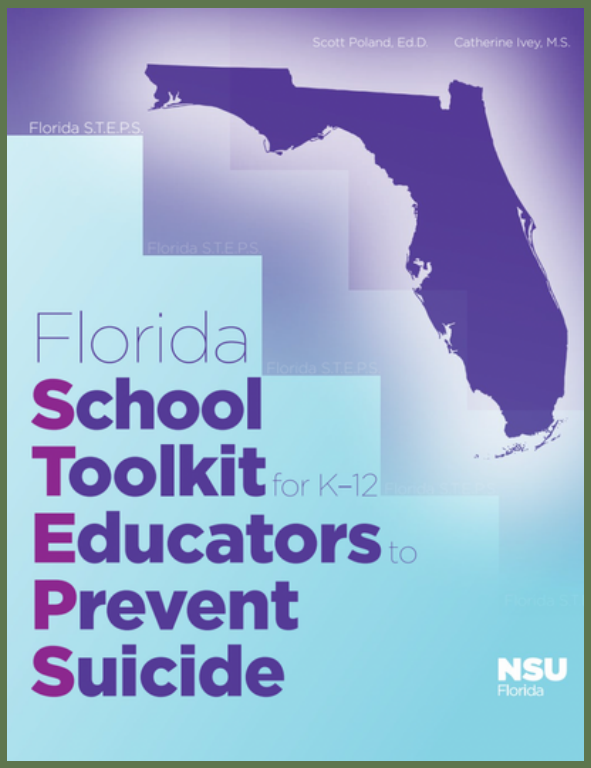
11/13/2023 - Dr. Poland and Dr. Hubbard were recognized at the External Funding Recognition Reception.

11/16/2023 - Dr. Poland, Dr. Hubbard, and Gregory Gayle discussed "Zero Male Suicide" in celebration of International Men's Day hosted by the College of Psychology and the BEDI Books+More Club.

1/25/2024 - Dr. Poland and Dr. Hubbard presented STEPS for the Institute of Small and Rural School Districts.

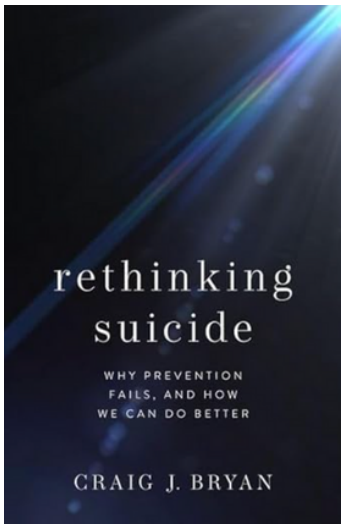
Upcoming Events

2/14/2024 - Dr. Hubbard, Dr. Poland, and Katlyn Bagarella will be presenting on STEPS for the National Association of School Psychology.



View the STEPS manual here!

Interview with Dr. Craig Bryan



Drs. Scott Poland and Juliette Hubbard had the opportunity to have an interview with Dr. Craig Bryan, a clinical psychologist and prominent figure in suicide prevention research. Dr. Bryan is the the director of the division of recovery and resilience, trauma program, and suicide program as well as the Stress, Trauma, and Resilience (STAR) professor of psychiatry and behavioral health at the Ohio State University College of Medicine. He conducts research on effective treatments for suicidality and PTSD. He is a military veteran and is experienced in working with military and first responder populations. Dr. Bryan is the author of the book, "Rethinking Suicide, Why Prevention Fails, and How We Can Do Better."

Scott Poland (SP): What influenced you to write this book and rethink suicide?

Craig Bryan (CB): A few different origins of thinking on that but a lot of it really came from first off working with suicidal people coming in for therapy and clinical intervention. Hearing from so many of them that the factors that were really the source of their distress were not clinical issues; they were not medical problems, like depression or anxiety. It was environmental factors. It was burnout, it was frustration with conditions at work or conditions at home. Along those same lines, we often found on our team that there is this subgroup of patients, where therapy is not the intervention that they need, it is a bigger paycheck, it is a better job, it is reliable housing. And so, what does that mean from a treatment intervention perspective? There are implications from more of a social policy type of perspective. I think the other line that influenced me is hearing stories from family members and friends, and people who have lost loved ones to suicide. It has really struck over the 15 or so years I have been doing this how often people would say things like "we did not see it coming," "that was the last person we would have expected to have killed themself," and "there were no warning signs." In many cases, I find that these survivors of loss are tortured, they are Monday morning quarterbacking, and they are blaming themselves. It happens so often that maybe it really does happen out of the blue. It was not mental distress in terms of a mental health condition, but sometimes chronic issues in their life, sudden things that knock you off balance like finding out that your partner is cheating on you or that you are in legal trouble and reacting to these life circumstances.

SP: Those are good points and I know you were in the military, and I was too. I finally tracked down one of my old army buddies and I had to pay for an investigator to find him. I was so shocked and saddened that he died by suicide a few months ago. His wife is devastated but so puzzled about the warning signs not being there other than sleep and anxiety issues.

Interview with Dr. Craig Bryan

CB: Over the past year, I was on the DoD's Independent Review Committee for suicide prevention. We visited all these military bases around the world, did interviews and focus groups with thousands of military personnel, and it was striking how often quality of life issues were at the forefront. One of our predetermined questions was something along the lines of what is the biggest source of stress for you right now, what makes life challenging, and the responses were like my computer does not work, my email does not work, the printers do not work, the barracks that I live in are really poor quality, and the elevators are not working. What was interesting is these quality-of-life things, were obviously sources of stress and created mental strain within the person's life. In some cases, someone cannot get their job done in a timely manner because they do not have the equipment, so they stay late which then interferes with their ability to connect with family, friends, and then their spouse is mad because they are always working. They are also getting text messages after hours from a supervisor with meaningless, petty things and they are never really off duty. It was symbolic of "the organization does not care about me," "I am not important enough to have good housing," and it often snowballed over time. It was very interesting how often the origins of these issues were just life circumstances.

SP: So, we know that [individuals who endorse suicidal ideation] have often traveled a long path. Regarding the question of impulsivity, there's some data out there that sometimes it is only a minute or even seconds that someone decides to end their life. What are your thoughts on the impulsivity factor?

CB: I am writing a paper right now and we are using the term "rapid intensification" instead of impulsivity. The reason is because "impulsivity" is often used, particularly amongst clinicians, as a personality trait. But what I think we are really talking about is this notion of fast, rapid transitioning. You go from ok to not ok, incredibly fast. It is striking, we have heard it from people, it is sometimes very explicitly in our face in data sets and then other times it is implied in data, but we have not measured it very well and so now I think where we can start to understand this process is with ecological momentary assessment (EMA). We send surveys to people every few hours during the day, we also have people wear Fitbits, and we monitor their heart rate, stress levels, and things like that. In this paper I am working on right now, when you look at suicidal ideation in the graphs, among a healthy, community sample, most of the time their suicidal ideation scores are zero, but then you see these sudden spikes where within the span of just a few hours they go from not being suicidal to very suicidal and then they come back down and they are not suicidal again. I think there is this phenomenon that we are starting to see this discontinuous change process, but our traditional methodologies and data analytic methods are not well suited to capture this sudden change process and this nonlinearity and that is a big part of our research now is to say this might explain why there is a subset of people who do seem to be ok and then suddenly they are dead. It does seem to be a real phenomenon of people who have this explosion of risk.

Interview with Dr. Craig Bryan

Juliette Hubbard (JH): I was going to talk about this conceptualization of suicide as a "wicked problem" with all these contributing and complex factors. I was immensely intrigued by that, but I found that when I tried to share that information with other clinicians or with other people who were working with people who had suicidal ideation, it was hard for me to break it down for them. I am wondering how you would go about training new clinicians, people who are just starting their work in psychology, to understand this as a more complex phenomenon than just "they have a mental illness, therefore they're at risk."

CB: I need to probably write more about that because the concept is not entirely familiar in many settings. It comes out of, in many ways, the social policy literature, like urban planning but also major social issues examples. Contemporary examples would be global warming or COVID containment. There are so many variables involved that you cannot just say here is the one thing we are going to do to fix this. I found that most people intuitively understand that suicide is complex they just do not know what that means. When I am training clinicians now and members of the lay public as well, I try to use metaphors and examples and one I found very helpful, it is in the book, is traffic fatalities. We often ask the question why people die by suicide and that is kind of how we design research studies but imagine if we were to ask the question why do people die in car crashes. Immediately we would see how hard it is to answer that question because it depends. There are many different factors involved. People will start to say people are drunk, that increases the risk of car crashes and that is right, but sober people die in car crashes too. If it is raining out, its hazardous conditions, but sometimes people also crash on a beautiful sunny day. What it comes down to is this combination of variables that at the right place, at the right time, a perfect storm happens at this event. For that reason, we cannot necessarily say that suicide or a car crash is caused by this thing. It is also not possible to say that it is caused by this combination of 5 or 6 things. There are many, many different, arguably infinite combinations that can occur. But that's ok, even though it is a complex phenomenon that does not mean we cannot do anything. It just means we have to recognize that we will probably have to use a multitude of strategies to block the different pathways to suicide and we should not get into a "one size fits all" type of approach or put "all of our eggs in one basket." I fear that is what we have largely done is because we only see it as a mental health problem, we immediately go to mental health treatment as the solution when that is not going to prevent all suicides, it cannot.

SP: We are really dedicated to prevention in Florida K to 12 schools and here at the university level. Do you have any key recommendations for us?

CB: I had a conversation with the CEO of The JED Foundation, and he had this nice way of framing things in schools, elementary all the way up to college age. He says that these are bounded communities, and, in that sense, it is similar to the military as well. You are in the community, or you are not. There are clear distinctions even though it is open. You can move in and out.

Interview with Dr. Craig Bryan

There is this sort of boundary around who is in versus who is not in the community and because of that you have a little bit more influence on what happens within the community. I have found it very helpful to think about suicide prevention in schools and organizations like that from the bounded community perspective. I think the other aspect of it is to first recognize that there are probably different types of suicides and different pathways to suicide. What that means is we need to ensure that people have easy, ready access to mental health treatment, but specifically suicide focused treatments. Treating depression does not seem to reduce suicidal behavior. We have to go directly for the factors that give rise to suicide. There will always be a role for that but there are also strategies that need to be employed around how peer groups work with each other, relate to each other, and how to support the formation as well as the maintenance of positive peer groups. But also, how to target and perhaps try to undermine unhealthy peer influences and peer networks. How can we educate family members and others within the community to think about environmental safety factors, especially how personal firearms are locked up and stored within homes? The other interesting thing as it relates to schools, especially younger like elementary through high school, is that suicide rates are increased during the school year. We see declines during spring break, Christmas break, and summer months. There is something about being in school that is probably creating more stress and social pressure on people. That is one of the interesting things we are starting to learn now with COVID was that not being in school seemed to be protective for many kids. That ties back to what I was saying before: what is it about the social environment that can potentially be modified or where we are removing things that can be potentially psychologically harmful in the same way that we would approach kind of protecting people from other types of environmental hazards. I am thinking of this now because we just moved into a new building, and we cannot hang up anything in the walls because there is asbestos. There are all these protections, so we do not have asbestos exposure. And so, how do we take a similar approach when it comes to these psychological exposures that can create harm and create stress?

JH: That brings me to the question of restricting access to lethal means. That is something we talk about a lot and we are big advocates of. But how do you recommend handling that issue or where do you see our role in that in a climate where it can be a very divisive thing to bring up.

CB: What we are learning in our research right now is that we definitely need to focus on social norms changing. We do trainings and presentations on firearm secure storage and it is interesting because when you start you can see people are uncomfortable, they are tense, their arms are crossed. But we break it down and present a true public health model and injury prevention model of suicide and say the good news is we can prevent suicide even though we do not know who is suicidal or when suicide is going to happen, by making it hard to die by suicide. And how can we make it hard? Well, we can increase survival rates. How do we do that? Again, we limit or reduce access to the most dangerous things in the environment.

Interview with Dr. Craig Bryan

So, you can still be a firearm owner, but maybe responsible firearm owner should mean waking up and storing your firearms, so your kids cannot get the gun. When they had a bad day, when they find out that their boyfriend or girlfriend is going to break up with them and they come home early from school and you are not home yet, you are not there with them when they are dealing with that raw emotion. We have published research on this and have found that it shifts people's thinking. And we are finding now that is something that we can collectively do is introduce the idea of what we are talking about is not removal of firearms or gun control, but how to safely store, secure, operate, firearms in the same way that we take other environmental precautions within our lives to make sure our homes do not burn down or get caught in a disaster.

JH: Where would you like to see the field of suicide prevention in the next 10 or so years?

CB: Good question. The reality is suicide research is fairly young. It has only maybe been within the past 50/60 years that we have made dedicated efforts towards suicide prevention so we are still in our infancy, and what I hope will happen over the coming years will be the adoption of more sophisticated research methods and data analytic techniques. Especially, as now we are starting to begin recognizing the nonlinear, complex nature of suicide risk. Our traditional compare the mean of group A to group B is not sufficient. It is ok but it is not good. We need to be better than that. Related to that on the intervention side, I have been thinking about how we approach suicide screening and treatment and I find that one of the biggest hang ups right now that I hope changes in the future, is we need to get over our obsession with screening for suicidal ideation. It is an unreliable method; it has always been unreliable. But instead of the field owning it and being comfortable with that uncertainty which I think would spur creativity on how we can then get better, I worry we are insisting on doubling down. Everybody needs to screen all the time, everywhere, constantly asking people are you having thoughts about suicide, and it is kind of obnoxious. My hope for the future is that the field will be more comfortable with the limits of our knowledge and use that as a motivator to innovate and to develop newer methods that will work much better. I would say the same on the treatment side is that right now very few mental health professionals are using evidence-based treatments. We have effective treatments for suicide prevention. It is just that very few clinicians know how to use them effectively. I have found that the disappointing part is clinicians often work really hard to not adopt better principles. They stick with what they know. They will actually argue with you on the better way that's proven. I think it is sort of baked into the culture of mental health disciplines. It is an unwillingness to evolve, in essence.

SP: We train clinical students and school psychology students. Is there anything else that you would like us to emphasize when we are training these soon to be professionals.

Interview with Dr. Craig Bryan

CB: When I had Ph.D. students at the University of Utah, one of the required readings for me with all new students and postdocs was this one-page essay called “The Importance of Stupidity in Scientific Research.” Basically, the thesis is that science is about comfort with what we do not know and that the most important discoveries and advances that have had the most impact and most consequence on improving human wellbeing came from research and science where someone in essence said I do not know, and I am ok with being stupid. I am going to use my stupidity to push in new directions and I will probably be wrong most of the time but that is ok because that is a part of the scientific process. Much of research right now and I think this is the case in suicide research, it is more about being right and looking smart, and being an expert and that holds us back. I very strongly encourage students to be productively stupid. Let us just admit that we do not know why people die by suicide and if we are comfortable with our stupidity, we will come up with innovative questions that will help us to solve this problem.

SP: We highly recommend your book rethinking suicide. Any other final thoughts or things that you would like to share with us?

CB: One final thought that is related to the productive stupidity concept is I encourage students, trainees, but also professionals to have a mindset of continual improvement. A lot of my research is on Brief CBT (BCBT) for suicide prevention, and I get asked these questions about what the best way is, and I know other treatment researchers in other fields are rigid about you doing it the right way, only my way type. My philosophy and outlook are that the way that we do treatment now, BCBT or whatever, is the best technology we have. My hope is that in 20 years we will look back at what we think right now is innovative and see it as obsolete. We will be reflecting in the future on what we did in the past, and we will say what were we thinking? Why did we think that was a good idea? But it is the best idea we have right now. I think that is an important frame to have in this space but also in other areas of life is to say it is ok if things do not stay the same so long as they are getting better. That is a process focused approach that is essential for addressing a wicked problem like suicide.

Firearm Safety

Scope of the Problem, Safety Suggestions, and How to Discuss it in Therapy

By Taylor Tejera, BA & Kate Fitzpatrick, BA

We are not advocating for or against the right to use firearms. Instead, this article aims to highlight the importance of reducing easy access to lethal means and preventing suicide.

The rise in suicide in the United States (US) has raised significant concern, particularly about access to lethal means. Firearms are often at the forefront of this conversation due to the high lethality and alarming prevalence of firearms used in suicide attempts. Shocking data shows that 90% of suicide attempts involving a firearm are fatal (Johns Hopkins Center for Gun Violence Solutions, 2023). In 2021, over 50% of suicides in the US involved a firearm (Centers for Disease Control and Prevention [CDC]). Notably, more gun-related suicide were reported than gun-related homicides during that year (Johns Hopkins Center for Gun Violence Solutions, 2023). A study conducted by Studdert and colleagues (2020) demonstrated that among California residents, men who owned handgun were nearly 8 times more likely to die of suicide via firearm than men who did not own a handgun. Women who owned handguns were also 35 times more likely to die by firearm suicide than their counterparts.

Notably, there are demographic groups that are more susceptible to firearm suicides. Older adults aged 65 and older pose the highest risk, with firearms being involved in approximately 70% of suicides in this age group (CDC, 2022). White males also made up 70% of all firearm suicides in 2021 (Johns Hopkins Center for Gun Violence Solutions, 2023). Firearms are responsible for a significant amount of veteran suicides as well (U.S. Department of Veterans Affairs, 2021). Additionally, those who have made previous suicide attempts, have a history of substance abuse, are cognitively impaired, are experiencing chronic pain, and have undertreated mental illness are at risk (Pallin & Barnhorst, 2021).

Moreover, the scope of this problem seems to extend to state-specific issues. The Kaiser Family Foundation assessed CDC Wonder data and found that in comparison to states with more gun laws, states with the least gun laws had more than twice the rate of firearm suicides (Saunders, 2022). In Florida, suicide presents a prevalent problem with approximately 63% of firearm deaths being suicides (Prevent Firearm Suicide, n.d.).

Hence, lethal means safety, and specifically firearm safety is crucial. Lethal means safety is a strategy that aims to reduce the easy accessibility for suicide attempt methods (SAMHSA, 2023). Delaying access gives people valuable time for suicidal ideation to decrease and seek services instead (American Foundation for Suicide Prevention, n.d.). Below are suggestions to safely store firearms and reduce ready access to firearms. Some tips on how to talk about firearm safety in therapy are discussed.

Firearm Safety

By Taylor Tejera, BA & Kate Fitzpatrick, BA

Ensure guns are unloaded, locked, and secured.

1. Store ammunition separately.
2. Choose a storage method:
    a. Cable Lock
    b. Lockbox or Gun Safe (lock case itself)
    c. Electronic Lockbox or Biometric Safe
3. See the US Department of Veterans Affairs Lethal Means Safety & Suicide Prevention for more information (https://www.mirecc.va.gov/visn19/lethalmeanssafety/)

How to Discuss Firearm Safety With Clients

- Make an effort to understand the relevance of firearms in the US. Be familiar with related laws and policies (Clay, 2020).
- The use of Firearms is a polarizing topic. It may be daunting to have a conversation about lethal means safety out of fear it will rupture the therapeutic alliance or offend your client. However, it is critical to not avoid the discussion. Research indicates that counseling on firearm storage may motivate firearm storage (Pallin & Barnhorst, 2021). It has been suggested that clinicians should start the conversation with open questions relating to the client's gun ownership while avoiding bias (Clay, 2020).
- Frame the conversation on reducing access to firearms. This will help avoid the client feeling that they are being judged for ownership (Clay, 2020).
- Develop a risk reduction plan that is individualized for the client. Some people may benefit from safe storage practices or giving their firearms to another person or establishment to prevent a crisis (Pallin & Barnhorst, 2021).
- Educate yourself on specific interventions and lethal means counseling that directly aim to reduce firearm injury risk. There are some organizations and courses that provide information on lethal means counseling that can assist clinicians. One is CALM: Counseling on Access to Lethal Mean which is a free online course (https://zerosuicidetraining.edc.org/enrol/index.php?id=20). The BulletPoints Project provides resources for clinicians and medical educators who are interested in firearm injury prevention. The BulletPoints Project website offers a free 1 hour course "Preventing Firearm Injury: What Clinicians Can Do" that is eligible for Continuing Education Credit (https://www.bulletpointsproject.org). The site also provides information on appropriate interventions and how to talk about firearm injury risk in counseling.

*References on page 17

Perinatal Mental Health

By Taylor Tejera, BA

Pregnancy and birth are one of the most important milestones in an individual's life. Pregnancy is a transformative experience, resulting in major physical, hormonal, and emotional changes. To many, the creation of life is enjoyable and exciting. However, the time between pregnancy and one year postpartum also called the perinatal period, still comes with challenges. Individuals may endure new and uncomfortable symptoms, such as body aches, fatigue, cramping, and morning sickness (Office on Women's Health, n.d.). Others may also struggle with significant mental health concerns. For instance, nearly 20% of women report having a mood or anxiety disorder during pregnancy (Uguz et al., 2019). One in seven women experience postpartum depression (PPD) as well (Mughal et al., 2022). Research also emphasizes concerns for individuals who endorse postpartum psychosis. While it is not a common condition, its symptoms pose a significant risk to the mother and child. A study showed that the first onset of affective psychosis is 23 times more likely to occur within 4 weeks after delivery (Bergink et al., 2016). Moreover, research demonstrates that suicide is one of the leading causes of pregnancy-related death with approximately 20% of women dying by suicide postpartum (Chin et al., 2022). This alarming data among this population underscores the importance of being vigilant and monitoring perinatal mental health.

It is important to note that perinatal mental health concerns affect certain groups disproportionately. A study conducted by Tabb and colleagues (2020) showed that Asian and Black women were more likely to report suicidal ideation than White women immediately following birth. Another study indicated that individuals who identify as LGBTQ2S+ may also be more likely to experience perinatal depression and anxiety (Kirubarajan et al., 2022). Although research primarily focuses on the experiences of cis women, evidence suggests that gender-diverse and nonbinary individuals are also more vulnerable to mental health issues during this period. Specifically, there is nonbinary and trans individuals face distinct perinatal mental health-related experiences including, dysphoria, isolation, exclusion, and a lack of competent care (Greenfield & Darwin, 2021). Literature also tends to highlight the perinatal mental health of only mothers, overlooking the impact on fathers. A literature review indicated that 10% of fathers experience postpartum depression and that fathers are more susceptible to depression when the mother is depressed (Fisher, 2016).

Given the vulnerability of negative mental health factors during this perinatal period, everyone needs to be aware of the warning signs and risk factors for these conditions. Risk factors for perinatal depression include a history of mental illness, being among a lower socioeconomic status, experiencing domestic violence, and engaging in substance use (Yang et al., 2022).

Perinatal Mental Health

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Some risk factors for perinatal suicide among women include younger age, being single, not having planned to be pregnant, experiencing domestic issues and discrimination, and psychiatric history (Orsolini et al., 2016). We recommend that people who are pregnant seek services in the case that they feel they are having changes in their mental health. Below are resources.
*References on pages 17-18

National Maternal Mental Health Hotline
Call or text: 1-833-TLC-MAMA (1-833-852-6262) for 24/7 support before, during, and after pregnancy in English or Spanish (interpreter services available in 60 languages). The hotline provides resources and referrals.

https://mchb.hrsa.gov/national-maternal-mental-health-hotline

Visit Psychology Today for Providers
https://www.psychologytoday.com/us/psychiatrists/fl/broward-county?category=pregnancy-prenatal-postpartum

Mothers Overcoming Maternal Stress (M.O.M.S)
https://www.hmhbbroward.org/moms (double check if appts available)
https://www.hmhbbroward.org/programs

Florida BH Impact
https://flbhimpact.org/

The American College of Obstetrician and gynecologists Assessment and Treatment of Perinatal Mental Health Conditions
https://www.acog.org/programs/perinatal-mental-health/assessment-and-treatment-of-perinatal-mental-health-conditions

Postpartum Support International
PSI HelpLine: 1-800-944-4773 (#1 Spanish, #2 English)
Text "Help" to 800-944-4773
Text en Español: 971-203-7773

Offers support group for certain groups and specific areas (queer and trans parents, South Asian moms, NICU parents, and many more)

Support groups in English:
https://www.postpartum.net/get-help/psi-online-support-meetings/

Support groups in Spanish:
https://www.postpartum.net/en-espanol/

Autoimmune Disease & Suicidality

By Kate Fitzpatrick, BA

Autoimmune disorders constitute a wide-ranging group of interconnected conditions where an individual's immune system targets and assaults the very tissues and organs it is designed to defend (AARDA, 2023). In usual circumstances, the body's immune system safeguards it by responding to invading microorganisms like bacteria and viruses (AARDA, 2023). Antibodies, specialized proteins that identify and eliminate these invaders, are produced by the immune system (AARDA, 2023). Autoimmune diseases arise when these antibodies mistakenly attack the body's cells, tissues, and organs (AARDA, 2023). There are more than 100 known autoimmune diseases, and it is reported that 1 in 5 Americans suffers from one (AARDA, 2023).

Scientists do not yet fully understand the immune system or what causes the body to produce an immune response to itself. However, we do know that several triggers play a role in developing an autoimmune disease. Hormonal changes and stress may lead to the onset of an autoimmune disease or “flare ups" of the illness (Isung et al., 2020). Keeping stress levels at bay is crucial to the progression of many autoimmune disorders (Isung et al., 2010) and clinicians should keep this in mind when working with individuals who have these conditions and experience high levels of life stress. People with autoimmune diseases also tend to experience overlapping pathology of anxiety and depression, which may complicate the presence of stress and exacerbate symptoms of suicidality (Isung et al., 2020).

Depression is common in many autoimmune disorders, and in diseases like Multiple Sclerosis (MS), people report higher than average rates of depression (i.e., approx. 40%) and death by suicide may account for about 15% of deaths (Lewis et al., 2017; Sadovnick et al, 1991). A longitudinal Danish study comparing suicide rates of MS patients with unaffected individuals stated that the suicide rate was reported to be twice as high as the general population in Denmark at the time and that the heightened risk was particularly elevated during the first year after diagnosis (Bronnum-Hansen, 2005). In addition to MS, many other autoimmune diseases reveal correlates with suicidality, including rheumatic diseases such as systemic lupus erythematosus, osteoarthritis, rheumatoid arthritis, and fibromyalgia (Li et al., 2018). Suicidal ideation and suicide attempts were found to be significantly higher in individuals with rheumatic disease, with 26% endorsing active suicidal ideation and 12% endorsing suicide attempt or completed suicide, compared with the general population at 3.1% and 1.0%, respectively (Li et al., 2018). Literature harps on the idea that the presence of an autoimmune disease exacerbates the risk, but much of the research leaves out integral mechanisms behind why the risk is heightened, and whether the diagnosis itself increases suicidality or the facets and symptoms of the disease.

A study by Brundin et al. (2016) explains that many studies had not yet examined the mechanisms behind the actual disease that heightens suicide risk.

Autoimmune Disease & Suicidality

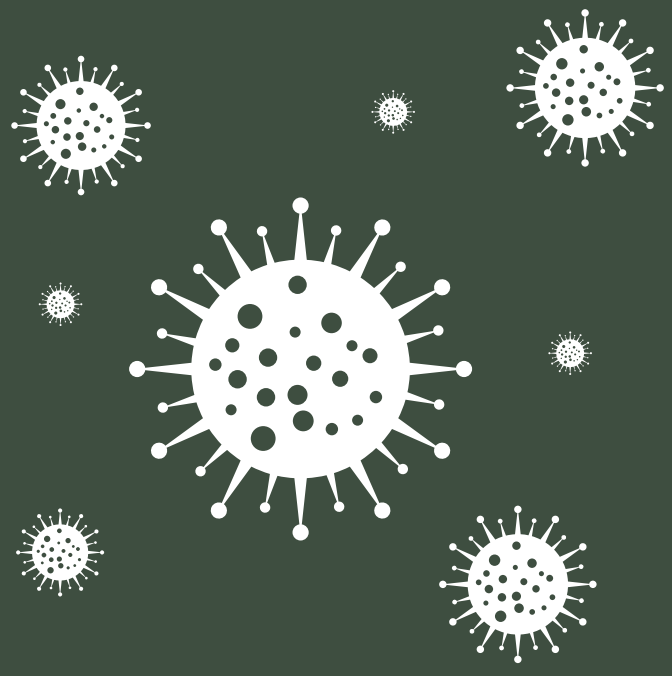
By Kate Fitzpatrick, BA

However, one of the components outlined in the article is inflammation. Inflammation is seen in individuals with suicidal ideation or attempts as a key contributor to depression and suicidality (Brundin et al., 2016). In diseases like MS, neurological inflammation is a component of development for the illness, characterized by motor loss, cognitive impairment, fatigue, and sensory loss (e.g., numbness and tingling) (Bronnum-Hansen, 2005). Inflammation is also a present component of most autoimmune disorders (Brundin et al., 2016), therefore, this may be an area of future research that is important in understanding the mechanisms behind mental health outcomes for those who suffer from these conditions. This is also crucial for physicians and mental health clinicians to consider when evaluating individuals and assessing for risk in a thorough and empathetic manner, paying attention to all symptoms of the illness. Interpersonal Theory of Suicide (Joiner, 2005) highlights the catalyzing effect that a lack of hope for the future or purpose can have on thoughts and actions toward suicide in an individual. When given an autoimmune diagnosis, a person's life is impacted in varying ways. Instillation of hope for an individual battling an autoimmune disease as well as providing them with all resources necessary is an important step we as clinicians can take to best serve this population. Check out the links below to learn more about resources for people with autoimmune diseases and more detailed information about conditions.
*References on page 18

"Autoimmune AWARE" Chronic illness support group that allows participants to share, learn and connect with others living with chronic illness via ZOOM
https://www.autoimmuneinstitute.org/resources/support-group/

The Wren Project: Listening support for people with autoimmune disease
https://www.wrenproject.org/

AARDA 2023 pamphlet
https://autoimmune.org/wp-content/uploads/2019/12/1-in-5-Brochure.pdf



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Suicide & Violence Prevention Resources

Center for Student Counseling and Well-Being
954-424-6911 (available 24/7)
www.nova.edu/healthcare/student-services/student-counseling.html

NSU Wellness
(mental health services for NSU employees)
1-877-398-5816; TTY: 800-338-2039
www.nova.edu/hr/index.html

National Suicide Prevention Lifeline
1-800-273-TALK (8255) or 1-800-SUICIDE
www.suicidepreventionlifeline.org
Veterans: Press “1” or Text 838255
Chat: www.suicidepreventionlifeline.org/chat
TTY: 1-800-799-4889

Crisis Text Line
Text: “Home” to 741741
Mobile Crisis Response Teams
(for on-site crisis assessment)
Broward (Henderson): 954-463-0911
Palm Beach: North: 561-383-5777
South: 561-637-2102
Miami-Dade (Miami Behavioral): 305-774-3627

Broward 2-1-1 Help Line
2-1-1 or 954-537-0211
211-broward.org
Chat:
https://secure5.revation.com/211FirstCallforHelp/contact.html

Palm Beach 2-1-1 Help Line
2-1-1 or 561-383-1111 or 211Palmbeach.org

Jewish Community Services of South Florida
305-358-HELP (4357); 305-644-9449 (TTY)
www.jcsfl.org/programs/contact-center/

Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locators
www.samhsa.gov/find-help

The Jed Foundation (JED)
www.jedfoundation.org

Suicide Prevention Resource Center
www.sprc.org

Suicide Awareness Voices of Education
www.save.org

The Depression Center
www.depressioncenter.net

Yellow Ribbon International
www.yellowribbon.org

Florida Initiative for Suicide Prevention
www.fisponline.org

Florida Suicide Prevention Coalition
www.floridasuicideprevention.org

Suicide & Violence Prevention Resources

National Center for Injury Prevention and Control
www.cdc.gov/ncipc/dvp/suicide

American Association of Suicidology
www.suicidology.org

American Association for Suicide Prevention
www.afsp.org

Florida Department of Children and Families: Suicide Prevention
www.myflfamilies.com/service-programs/mental-health/suicide-prevention


Thank you