SUMMER COLUMN FROM THE PRESIDENT

Scientific data reasonably supports the finding that people with high blood levels of the amino acid homocysteine are at increased risk for heart disease and stroke. Logic would tell us, then, that reducing homocysteine levels should cut that risk. In fact, that has been the prevailing belief; and the treatment of choice to accomplish that reduced level of homocysteine has been a combined regimen of folic acid and vitamin B12.  

A recently published, 7-year double-blind, randomized, controlled trial of more than 12,000 survivors of myocardial infarction by a group of Oxford University researchers, however, found no significant differences in the proportion of coronary events or deaths attributed to vascular causes in treated patients versus those receiving a placebo.1

So, if A Causes B, then why does reducing A not effectively reduce B? Of course, the reason is — the logical fallacy: cum hoc ergo propter hoc. You see, blood homocysteine levels (A) are positively associated with cardiovascular disease (B), but blood homocysteine levels (A) have never been shown to be causal of cardiovascular disease (B).

A great deal of what we know and understand about suicide is of this sort. Consider the frequency with which we publish and disseminate symptoms of depression as signs of suicide, because everyone knows that depression causes suicide, right? There are even billboards strung across the US emphatically stating “Depression, the Number One Cause of Suicide.” Thomas Joiner in his new book, Myths about Suicide2 offers another example, that of the significant association between breast augmentation and risk of suicide, one better explained by differences between women who seek this cosmetic procedure and those that don’t than by some causal pathway between augmentation and suicide.

Suicidology and suicide prevention are no different than a host of other public health issues in that we suffer from the fervent desire to find the magic bullet (admittedly a bad metaphor when discussing suicide) — in this case two magic bullets, that of a simple explanation leading to a simple, immediately compelling preventive intervention. Discovering the Holy Grail would be more likely. We are dealing with an immensely complicated behavior, multifatorial caused and not subject to easy solution. We have spent an enormous part of scant resources on single bullet interventions with, not unexpectedly, nowhere near the hoped for results in the way of reduced rates of suicide and non-fatal suicidal behaviors.

Consider the following description of just one person at acute high risk of suicide/suicidal behavior and ask yourself which single individual factors of risk would you need to diminish or remove from this description to feel comfortable that this described patient was no longer at acute high risk.

A middle aged, white male is clinically depressed. He drinks excessively and frequently, to the point that his wife is threatening to leave him. He has marked symptoms of anhedonia, insomnia, social withdrawal, and increasingly poor concentration; his work performance has suffered and his supervisor has put him on probation, demanding improved performance or face the possibility of termination. He has talked of feeling hopeless; and has expressed vague suicidal thoughts — he has no plan. He owns a firearm. He meets Axis II criteria for narcissistic personality disorder. He has steadfastly refused to seek psychiatric care as he thinks psychiatry is a pseudo-science. 

Try removing just one of his risk factors and see if you believe that this man is less of a ticking suicidal time bomb. Try removing two and see if you feel more comfortable that you have succeeded in reducing his level of risk.

I trust that each of us well appreciates the complexity and difficulty of preventing suicide. We strive toward that end in a myriad of ways, often with inadequate or nonexistent funds, too often with, any, collaboration, partnership, and/or political will to create sufficient critical mass over the long haul to make change happen. Maybe this is why we persist in offering simple interventions - there is only so much any one of us can do. If this sounds familiar to you, you probably read of these themes in my column in the last issue of this newsletter. I repeat them here because this is the last chance I have to implore you to DO SOMETHING to exercise your community/ state/province, country toward suicide prevention on World Suicide Prevention Day, September 10, 2010.

The suicide prevention community is small; we have so much to do and we have an imperative to mobilize supports and demobilize barriers to effectively make the difference we wish to make. We are not going to accomplish much if we apply simple solutions to complex problems. This is but one day in the year where we all should be as active as possible to make the road ahead just a bit easier to travel and the targets of our efforts more achievable. IASP greatly looks forward to an international effort on World Suicide Prevention Day3. Thank you in advance for participating in that.

Lanny Berman, Ph.D., ABP

REFERENCES

REPORTS FROM NATIONAL REPRESENTATIVES

Suicide prevention in Belgium

In the federal state of Belgium, suicide prevention is a responsibility of the three constituting regions, i.e. the Flemish, Walloon and German-speaking regions. While the latter two regions have developed a limited number of suicide prevention activities, the Flemish government has initiated and supported a suicide prevention action plan since the beginning of this century.

This plan, of which the first phase runs from 2006 to 2010, aims to achieve an eight percent reduction in the number of suicides by 2010. In addition, the plan aims to reduce the occurrence of non-fatal suicidal behaviour, suicidal ideation and depression.

The plan is based on five strategies: 1. Mental health promotion at individual and societal levels. 2. Promotion of telehelp. 3. Promotion of the competence of professionals and the optimising networks. 4. Improve quality of media reports of suicide and decrease availability of a) Suicide attempts. b) Early detection and diagnosis of psychiatric disorders such as a schizophrenia c) Decrease occurrence of relapse in depressive disorder d) Children of parents with psychiatric disorders e) Gay and lesbian individuals and communities f) Suicide survivors.

Each strategy consists of a number of projects which were selected on the basis of evidence of efficacy and cost-effectiveness.

Between 2000 and 2007 the Flemish suicide rates (numbers per 100,000 inhabitants) decreased from 30 to 22 in males and from 11 to 9 in females. Taking into account the recent financial and economic challenges a continuation of this positive evolution remains to be demonstrated.

Professor Kees van Heeringen is Head of the Department of Psychiatry and Medical Psychology, and Unit for Suicide Research, University Hospital, Gent, Belgium, e-mail: comitee.vanheeringen@UGent.be

Suicide prevention in the USA

In 2006 the US recorded 33,300 suicides. Males continue to surpass females in deaths (4:1), while female attempts occur at a greater rate (3:4:1). Rates for youth and middle aged adults appear to be on a slow rise, but a slight decrease has been observed in suicides among senior citizens. Increasing trends seem to be emerging among African American males and Hispanic/Latina females (youth) while American Indian rates continue to be higher than the nation’s 11.1/100,000 rate. Firearms continue to be the leading method of suicide in the US (50.7%), followed by suffocation and hanging (22.5%) and poisoning (19.3%). The highest rates are found in the mountain west and rural areas.

Many positive initiatives are addressing these issues. The Action Alliance for Suicide Prevention will be a public/private partnership to help establish national priorities. The Secretary of Defense convened a Panel of experts to address suicide in the armed services and authorized $30 million in funding for a large scale study of suicide.

The Suicide Prevention Resource Center (SPRC) and the National Suicide Prevention Lifeline (NSPL) and recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) also created a Suicide Prevention Branch to dedicate staff, time and a more focused effort to address the issue of suicide.

The SPRC brings research to practice offering training and technical assistance and co-ordinating the Best Practices Registry for effective suicide prevention programs. The SPRC has produced high quality materials and in just eight years 48 of the 50 states have developed lifespan suicide prevention plans with the SPRC providing their technical support. Over $100 million in federal funding from the Garrett Lee Smith Memorial Act has reached 42 states, 18 tribal grantees, 1 tribal territory and 66 college campuses since 2005; all assisted by the SPRC.

The NSPL has a network of 145 certified crisis centers across the country ensuring 24/7/365 coverage of phone lines for people in crisis. The monthly call volume is over 50,000 calls from 49 states.

The National Council for Suicide Prevention (NCSPP) is the leading voice for suicide prevention and survivors in the US. Efforts to raise awareness of the importance of learning the warning signs through social and traditional media initiatives are underway for World Suicide Prevention Day 2010.

The National Violent Death Reporting System (NVDRS) is a surveillance system that collects and links data from many sources into a central database. Currently, 18 states submit information to the NVDRS with the goal to ultimately fund this service to all 50 states.

Finally, a Task Force was convened to begin reviewing and updating the Media Recommendations for Reporting on Suicide with Version 2.0 expected to be completed by the end of 2010. New media as well as updated recommendations with recent research will be included.

Dr. Daniel J. Reidenberg, Psy.D. is Executive Director of the Suicide Awareness Voices of Education (SAVE) and Managing Director of the National Council for Suicide Prevention (NCSPP), e-mail: drreidenberg@save.org

Daniel J. Reidenberg

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Seminar on Suicide Prevention in Pakistan

Aga Khan University and the Suicide Prevention Research Interest Group (SPRiNG at AKU) in collaboration with John Hopkins Bloomberg School of Public Health, hosted Pakistan’s first national seminar titled Suicidal Realities in Pakistan on September 30, 2009. The seminar was organized by Dr Muhammad Shahid, a Fellow in Injury Prevention, Johns Hopkins Bloomberg School of Public Health and Assistant Professor, Department of Emergency Medicine, AKU.

The seminar included lectures by Dr Murad Moosa Khan, Chairman and Professor, Psychiatry, Dr Ehsanullah Syed, Associate Professor, Psychiatry, Dr Nargis Asad, Assistant Professor, Psychiatry, Dr Haider Ali Nazvi, Assistant Professor, Psychiatry, Dr Muhammad Zahid Bashir, Assistant Professor, Pathology & Microbiology and Dr Muhammad Shahid, Assistant Professor, Department of Emergency Medicine. The second part of the seminar included a workshop on Suicide Risk: Identification and management. The programme was hosted by Dr Muhammad Junaid Patel, Assistant Professor, Department of Medicine. Muhammad Shahid, MBBS MPH MSc MCPS FCPS, Assistant Professor, Department of Emergency Medicine, Aga Khan University, Karachi, Pakistan, e-mail: muhammad.shahid@aku.edu

43RD ANNUAL AMERICAN ASSOCIATION OF SUICIDIOLOGY
CONFERENCE DRAWS RECORD ATTENDANCE

A record 870 researchers, clinicians, public health specialists, crisis center staff members, survivors and others involved in the study and prevention of suicide assembled in the city of Orlando, Florida, 21st -24th April 2010 to attend the 43rd annual conference of the American Association of Suicidology. Competing for attendees’ attention to the sights and sounds of nearby Disney World and Mickey Mouse and friends were more than 175 paper presentations, workshops and panels in addition to 18 half and full-day pre-conference workshops.

Renowned family therapist Monica McGoldrick keynoted the opening day’s plenary session with an exploration and celebrity examples of family risk of suicide. Other plenaries dealt with topics as diverse as suicide among veterans, an empirical test of the often-phrased “six survivors for every suicide,” and recommendations for improving continuity of care. In addition major panel presentations were made on homicide-suicide; helping children heal after a suicide of a parent; distinguishing non-suicidal self-injury and suicide; and recommendations for improving continuity of care. In addition major panel presentations were made on homicide-suicide; helping children heal after a suicide of a parent; distinguishing non-suicidal self-injury and suicide; and the impact of suicide on cultural systems and clinicians.

Past AAS president Frank Campbell received the association’s prestigious Dublin Award (for career contributions), and harvard University psychologist Matt Nock was awarded the Shneidman Award (for outstanding research contributions). His presentation on A New Direction in Measuring the Suicidal Mind sparked a great deal of interest among researchers in attendance.

TASK FORCE:
The IASP Task Force on Genetics and Neurobiology of Suicide

We all know that suicidal behavior is a major health problem worldwide. Each year more than 1 million people die by suicide and between 100 and 200 million people engage in suicide attempts.

The risk of suicide-related behavior is supposed to be determined by a complex interplay of socio-cultural factors, psychiatric history, personality traits, and genetic as well as neurobiological vulnerability.

Major goals of this Task Force are to promote studies of genetic aspects of suicide ideation and behaviour among suicidologists on one side, and to promote genetic studies of suicide ideation and behaviour among behavioural geneticists on the other. This genetic view is supported by adoption and family studies indicating that suicidal acts have a genetic contribution that is independent of the heritability of Axis I and II psychopathology. The heritability for serious suicide attempts is estimated to be 55%. Furthermore, there are long known findings in neurobiology, such as a decrease of serotonin metabolite (5-HIAA) levels in patients with suicidal behaviour.

This Task Force will provide a place where scientists interested in the genetics of suicidal behavior can easily get in contact with each other and can cooperate and stimulate the whole field with innovative research and results. Further understanding of the genetics and patho-physiology of suicidal behavior is very important in suicide prevention. Therefore, we will organize workshops of the Task Force during the IASP meetings to meet each other, outline progress and discuss new developments in this exciting field.

On behalf of the members (P Baud, T Bronisch, P Courtet, V Delucia, I Giegling, F Karge, A Malafosse, J Mann, N Perraud, T Postolache, A Roy, P Salz, M Sarchiapone, G Turecki, K van Heeringen, M Voracek, D Yogesh, G Zalman)

Please contact me if you would like to be a member of this Task Force.

Professor Dan Rujescu, Chair of the IASP Task Force on Genetics and Neurobiology of Suicide, Department of Molecular and Clinical Neurobiology, Ludwig-Maximilians-Universität (LMU) Munich, e-mail: Dan.Rujescu@med.uni-muenchen.de

Dr Jerry Reed, IASP Chair of the Council of Organizational Representatives staffed the IASP display table making material available on the ESSS13 meeting in Rome, Italy to be held September 1-4, 2010; the 4th Asia Pacific Regional IASP conference to be held November 17-20, 2010 in Brisbane, Australia; and the XXVI IASP World Congress to be held September 13-17, 2011 in Beijing, China to all who visited the display. All who stopped by during breaks were encouraged to become members of IASP to strengthen our collective voice worldwide.

IASP members are welcome to attend next year’s 44th annual AAS conference meeting in April in Portland, Oregon.

Dr. Mort Silverman, IASP Member and former US National Rep; Dr. Dan Reidenberg, IASP Member and current US National Rep; Dr. Lanny Berman, President IASP; and Dr. Jerry Reed, Chair, Council of Organizational Representatives.

Dr Lanny Berman, IASP President
Obituary

Michel Hanus, pioneer in understanding and helping suicide survivors

Michel Hanus, who died on the 2nd of April 2010, was a pioneer in the development of programmes for bereaved persons and specifically suicide survivors in France and the European Community. Michel was a psychiatrist, a psychoanalyst and Doctor of psychopathology whose medical thesis was on “Pathological Grief.” He was President of the Society of Thanatology and the National Committee on Funeral Ethics in France. However, he is most known for being the founder of the French association “Vivre son deuil” – “Living with Bereavement.” This association, with many thousands of members, expanded to include 14 branches in France, Belgium and Switzerland where he continued to volunteer helping persons bereaved by suicide and developing support programmes in collaboration with other French organizations, including the Union Nationale pour la Prevention du Suicide, the Fédération Française de Psychiatrie and the Government Health General Directorate. He spent much time training trainers and expanding the network of people helping support the bereaved in Europe. He published nine popular books in France including general books on death and bereavement and the classic “Le deuil après suicide” (Mourning after suicide). Michel is survived by his wife and his five sons. Persons who would like to contact his family can send an e-mail to: famille.michel@hanus.fr

Professor Brian Mishara, Professor of Psychology and Director of the Centre for Research and Intervention on Suicide and Euthanasia (CRISE), University of Quebec, Montreal, e-mail: mishara.brian@uqam.ca

Contributions for the news bulletin are welcomed from other organizations. Please send any contributions to Dr Jerry Reed or contact him for advice about preparing your report. jreed330@comcast.net

Preview of ESSSB13

Dear Colleagues,

Time is running! The 13th European Symposium of Suicide and Suicidal Behaviour will be held on September, 1st to 4th in Rome, the city where past ages revive, overlap and melt into Modern Living and Transcultural Exchange. That’s why it represents the ideal ground for the theme of the Symposium which is “Integration of Knowledge for an Interdisciplinary Approach to Suicidology and Suicide Prevention”.

We are proud to inform you that we received more than 600 submissions of scientific contributions that will be presented in 6 plenary sessions, more than 60 parallel sessions and 4 poster sessions!

A very rich scientific programme will engage us during these 4 days, in a continuous and mutual exchange of ideas that will undoubtedly enrich and integrate our knowledge. Both IASP and IASR are involved in organizing different activities such as the Breakfast with Experts, Symposia and the Andrej Marusic Award.

For more details please, see the Symposium website: www.esssb13.org

Welcome to Rome!
The Presidents of Symposium

Preview of the 4th Asia Pacific Regional Conference of the International Association for Suicide Prevention

BRISBANE AWAITS YOU ALL!

Between 17 and 20 November 2010, the beautiful Brisbane, Land of the Queens, Australia, will host 4th Asia Pacific Regional Conference of the International Association for Suicide Prevention. The theme of the conference is: “Suicide Prevention: A Dialogue Across Disciplines and Cultures” a theme that strongly emphasises the two main targets of the conference: facilitating people of different scientific backgrounds speaking to each other, and facilitating people from different cultural backgrounds to identify commonalities and differences in relation to suicide and suicidal behaviour. Addressing transcultural differences is fundamental for us to progress in suicide prevention. Multidisciplinary approaches to suicide prevention have been my refrain for many years now, and – far from being an empty slogan – I am pretty proud to say that today the staff of my Institute includes psychiatrists, psychologists, sociologists, epidemiologists and health economists. Organised by the Australian Institute for Suicide Research and Prevention – AISRAP and Suicide Prevention Australia (SPA), with a fantastic scientific calendar, a seducing social program, and the complicity of a wonderful location for which weather is never an issue (“no worries, mate...”), the conference will constitute a truly exciting experience for all of those involved in the challenging mission of suicide prevention.

Book now! See ya, guys.

Professor Diego De Leo,
Conference President and Director of the Australian Institute for Suicide Research and Prevention – AISRAP, Doctor of Science and Professor of Psychiatry, Director, Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane, Australia, e-mail: d.deleo@griffith.edu.au

4th Asia Pacific Regional Conference of the International Association for Suicide Prevention

17th-20th November, 2010

The 4th Asia Pacific Regional Conference of the International Association for Suicide Prevention (IASP) is to be jointly hosted by Suicide Prevention Australia (SPA) and The Australian Institute for Suicide Research and Prevention (AISRAP).

For further information, see www.suicideprevention2010brisbane.org

XXVI IASP World Congress

13-17 September 2011, Beijing, China