GRIEVING NOTES
By Linda Vigil

In our work with intervention, prevention, and healing, after a completed suicide, we are constantly meeting new people.

I have often wondered why bad things happen to good people, and why some people are born beautiful and seem to have so very much handed to them, money, status, always chipper and cheerful!

We begin our lives where God plants us and we learn to bloom where we are planted.

When the Ball of Life is dropped in our lives, how we play ball is entirely up to us; we can choose to let the ball lie in one place, pass the ball to someone else, or choose to play ball (the game of life) and complete it. It seems much easier to make a good beginning of all our hopes and dreams of the future ...marriage, having children, our careers and relationships ...but to play ball and make a good ending, takes Faith and much more hard work.

Even through life's interruptions, severe illnesses, sorrowful intrusions and life's deepest tragedies, people continue to grow and share, realizing they are not alone in life's game!

Elisabeth Kubler Ross has said, "Death can show us the way to live. It's only when we truly know and understand that we have no way of knowing when our time is up -that we begin to live each day to the fullest, as if it was the only one we had."

It is so important not to give up the game, and not to think you can play everything by yourself. When life is going well, give credit to others and realize that you didn't do it alone.

With tragedy and sorrow, play the very best you can. Place life's meaning upper most at the time of deepest pain ...live with more than just surviving. Let yourself feel your deepest pain, anger, guilt, and honestly express yourself.

We advise survivors that there are only two things that they can do wrong in their grieving —hurt themselves or hurt someone else. Everything else you feel is part of the process in healing. Our Faith helps us through the struggles of life's pain and our Faith is the overlay in our lives.

God helps us in playing the ball game of life. We are in Healing

---

SUICIDE SCREENING IN SCHOOLS YIELDS RESULTS
By Megan Rauscher

NEW YORK - School-based suicide screening can identify students at risk for suicide and other mental health problems not recognized by school professionals, new research suggests.

"School-based screening can be an integral component of a school's mental health initiative and complement the work already being performed by school staff making for a complete program," Dr. Michelle A. Scott, from the Division of Child and Adolescent Psychiatry, Columbia University College of Physicians and Surgeons, New York, told Reuters Health.

In the early 1990's, evidence emerged that suicide awareness programs, which did not stress the association between suicide and mental disorders like depression, were not effective and, in fact, had a negative impact on those students who had made a prior suicide attempt, Scott explained.

Unlike prior prevention efforts that require a student to come and seek help on their own, school-based screening is a pro-active approach to identifying students who may be at risk for attempting suicide, she also noted.

That is to say, school-based screening asks students directly about their risk factors for suicide,

including thoughts of killing oneself, prior attempts, and mental health problems such as depression, anxiety and substance use. If a student is indicated to be at risk, they are further evaluated by a clinician at school to determine if an outside referral is necessary.

Scott and colleagues evaluated whether a school-based screening for suicide risk called the Columbia Suicide Screen was redundant to the work already being conducted by school staff, such as counselors, nurses and disciplinary staff.

Of 1,729 students from seven high schools in the New York area who completed the screening, 489 had a positive result, indicating that they were at risk for suicide. A total of 641 students (73 percent of those who had screened positive and 23 percent of those who screened negative) were studied further.

"This study found that school-based screening identifies students with significant mental health problems that school professionals did not already indicate being concerned about," Scott said. "However, it should be mentioned that there were students identified by the school staff that were not identified by the screening."

A Poem for Stephen Gregg Chumley

(03/15/62 - 02/25/08)

By Mitch Mulcahy

God called you home today, for a reason
How precious that must be.
You're meeting God today, for it's your season
Everyone loves you, including me.

Your life was one of splendor
Form and function were your goals.
But today, God took you with him
Lord, have mercy on our souls.

Friends and family are going to miss you
For what it's worth, you couldn't stay.
God has a plan, but it's a mystery
I wish I could have seen you one more day.

God called you home today, for a reason
How precious that must be.
You're meeting God today, for it's your season
Everyone loves you, including me.

You are our friend, you are our brother
But today, something's changed.
Our hearts are empty yet full of sorrow
Wondering why you've gone away.

God called you home today, because he needs you
You'll find serenity with him, you will see.
You're meeting God today, because he loves you
May peace be with you, our brother Steve.

HOW TO COPE WITH CRITICAL PEOPLE BY RICK WARREN

You're going to be hurt by other people in life -that's a fact. And those hurts leave scars that affect how you think, act and relate to others, The deepest wounds of all are caused by rejection. Undoubtedly you've experienced the pain of rejection in your life -from a parent, a spouse, a friend or even a stranger.
Sarcastic barbs, put-downs, belittling comments, criticism, gossip and ridicule, are all potent

weapons in the arsenal of rejection. For some of us, when we're hurt, the tendency is to strike back, to exact revenge. But the moment you retaliate, you give up control of your life to the person who angers and hurts you. "You make me so mad!" That is an admission of control. What you are really saying is, "You have power over me to determine how I feel."
Not all of us lash out when we're attacked. Some of us worry ourselves to death with resentment. But nursing a grudge never hurts the other person: It only hurts you.
So what should you do when you're under attack? Withdraw into a shell, hide in a cave, isolate yourself from humanity and say, "I'll never let another person hurt me again!" Definitely not. You can make a different choice. You can choose whether painful circumstances will devastate you or direct you to a new path.
It's unavoidable: Dealing with other people effectively is one of the most important things you can learn in life. After you've mastered that, you're about 95 percent down the road to finding happiness.
So? How do you handle the people who put you down?
Remember, you can't please everyone. Even God can't do that! While some are praying for God to send rain, others are praying for sunshine. It's foolish to attempt what even God can't do.
Realize that you don't need others' approval to be happy. We live in a society where we don't get a whole lot of approval. People do all sorts of crazy things trying to win a smile from someone too cold or too nasty to ever give it. Remember, you are as happy as you choose to be. So refuse to play the game! Don't waste any energy trying to convince un-placable disapproving people that you're a great person. The problem is not with you, but with their own insecurities
Refuse to retaliate. Striking back only lowers you to the naysayer's level of immaturity. Instead, pray for that other person! It will help both of you. Be an actor not a reactor.
Refocus on God's view of you. In the Bible we're told that God says you are lovable, capable, forgivable, acceptable and valuable. Now whom are you going to believe?
I've talked with so many successful women and men who are plagued with gnawing insecurity. Why? Because they are still replaying hurtful statements made to them years ago-statements that weren't true even then. How do you erase those tapes? By affirming what God says about you.
To a large degree your self-image is influenced by what you believe the most important person in your life thinks about you. That's why choosing emotionally healthy friends is so important. It is also why I recommend that you make God your best friend. If God loves you, and you love you, you don't need approval of un-pleasable people.

So - Why Ask Why ?
By Tim Jackson

Survivors can't stop asking why-at least for a while. Margaret Atwood describes a survivor's

incessant search for answers: Curiosity is not our only motive: Love or grief or despair or hatred is what drives us on. We'll spy relentlessly on the dead: We'll open their letters; we'll read their journals; we'll go through their trash, hoping for a hint, a final word, an explanation, for those who have deserted us-who've left us holding the bag, which is often a good deal emptier than we'd supposed.

The search for clues to help them understand moves survivors to ask, "What could they possibly have been feeling or thinking that made dying seem like the only option that they had left?"

What Caused Them To Choose suicide?
No one knows with certainty the final feelings or thoughts that push a person to suicide. But the brutal honesty of those who hurt so bad that they want to die provides insight into the overwhelming desperation and distorted determination that seems to best describe the turmoil churning within.

Overwhelming Desperation
T.S. Eliot wrote, "Man cannot bear much reality." Reality in a fallen world will eventually either drive us to God or to despair.
The desperate reality for those who take their own life often includes but is not limited to what seems like unbearable pain, intolerable isolation, and debilitating hopelessness.
Unbearable pain is much more than chronic physical pain. Internal anguish is the basic ingredient of a suicide. Acting on a death wish is the ultimate form of flight from the pain of unmet longings and seemingly insurmountable losses. A suicidal struggle is almost always a battle with ambivalence, but at some point death becomes more attractive. While most don't necessarily want to die, they simply don't want to continue to live with the pain that has become unbearable for them.
Intolerable isolation compounds despair. Much of what we long for is related to meaningful relationships within a family or community. Suicidal people often feel alone and confined to the darkness of their pain. They feel abandoned by God and by those they looked to for the love they craved.
It's difficult enough to endure pain with the help and support of others. But when a suicidal person is abandoned and alone, hope evaporates.
Debilitating hopelessness sets in when the pains and losses of life seem intolerable, when shameful consequences are unavoidable, and when a person feels his world is spinning out of control. He feels powerless and worthless.
A suicidal person often feels, "No matter how hard I try, I can't change what really matters to me. I'm such a loser. I don't deserve to live." With the illusion of control stripped away, the suicidal person, rather than openly facing what he's powerless to handle on his own, hides under a blanket of self-contempt and yearns to disappear. Self-destruction becomes the only

hope of escape from the pain and isolation.
"People seem to be able to bear or tolerate depression as long as there is the belief that things will improve. If that belief cracks or disappears, suicide becomes the option of choice."
Persistent, unfulfilled longings lead to a condition of hopelessness that infects the mind and distorts our determination to live.

Distorted Determination
Self preservation is normal. Self-sacrifice is learned. But the determination to self-destruct is the result of a darkened state of mind that has been altered by despair blinded by anger.
The demand for relief from the painful torment of living is the most obvious form of suicidal determination. As one suicide note read, "Of course, I do not want to die, but it is suffering to live."
Rather than battle through despair and cry out for help, the suicidal person loses all hope of ever being rescued-so he gives up. The demand for immediate relief from vulnerability is, in the end, an angry refusal to suffer while waiting for God to rescue-both now and in the hereafter.
An even darker side of suicidal determination can sometimes include the demand for revenge.
Most of us want to believe that people commit suicide to end their pain, not to create pain for others. But that's not always the case
Suicide can be the ultimate door-slamming exit that ensures nothing will ever be resolved.
From this vantage point, suicide is an act of immense cruelty and disdain for others.
As one survivor wrote, "Even as we begin to understand that our loved one killed (himself) in a desperate attempt to end (his) pain, we often feel that (his) anguish has not been extinguished but simply passed on to us."
The torment passed on is sometimes more intentional than incidental. The location, timing and violent method of a suicide can be choreographed to send a message. Survivors feel stained with indelible marks they can never wash off. They feel that the loved one who committed suicide was saying, "I'd rather die than live the rest of my life with you." "You didn't do enough for me." "How could you hurt me so bad?"
Nothing trumps suicide as the ultimate in-your-face form of rejection that leaves both an internal scar and an external stigma.
The tandem demands for relief and revenge betray the heart of the suicidal person -the angry refusal to trust anyone ever again. Suicide in such instances is the last desperate act of final rebellion against a hostile world and an uncooperative God, neither of which provided what was expected or wanted.

" Am I Going Crazy ? "
By Kenneth C. Grieve

I know a hospice worker who makes more than a thousand follow-up calls to grieving people every year to check in with them and see how they're doing. She first calls people one month after their loved one has died.
In these initial calls many people tell her that they can't concentrate on anything other than their loss, they have mood changes at the drop of a hat, or their life seems incredibly empty. Some say they are overwhelmed by feelings of anger, guilt, sadness, or loneliness, while others tell her that they are numb and don't really feel anything at all. Some say they feel like sleeping. Some tell her that they cry constantly, while others say they've been unable to shed a single tear.
Many describe how they have recurrent dreams about their loved one, and many say that there are even times when they think they hear their loved one's voice.
The hospice worker told me that after people describe their grief experiences, the most common question they ask is, "Am I going crazy?" Her response to them is, "No, you're not going crazy. Crazy feelings are normal in grief."
People have told me the same thing -that they felt they were going crazy during their grief. They were sure they were the only ones who had the thoughts or feelings they were having, so they began to fear they were abnormal. But then they began talking with other people who were grieving and quickly discovered that most of them had or were having the very same experiences. They discovered that their feelings were normal.
If you ever feel like you're going crazy, one of the best things you can do is to find others who are grieving or who know about grief and tell them what you're experiencing. You'll learn that your "craziness" isn't crazy at all -it's just a very normal part of grief.

REGARDING SUICIDE FACTS & DEPRESSION ISSUES
Suicide is a tragic, and many times a preventable death. In 2006, suicide was the 10th leading cause of death in the U.S. It has been estimated that there may be from eight to 25 attempted suicides per every one suicide death. The alarming numbers of suicide deaths and attempts emphasize the need for carefully designed prevention efforts.

Suicidal behavior is complex. Some risk factors vary with age, gender and ethnic group and may even change over time. The risk factors for suicide frequently occur in combination. Research has shown that more than 90 percent of people who kill themselves have depression or another diagnosable mental or substance abuse disorder, often in combination with other mental disorders. Research, also indicates that alterations in neurotransmitters such as serotonin are associated with the risk for suicide. Diminished levels of this brain chemical have been found in patients with depression, impulsive disorders, a history of violent suicide attempts, and also in postmortem brains of suicide victims.

Adverse life events in combination with other risk factors such as depression may lead to suicide. However, suicide and suicidal behavior are not normal responses to stress. Many people have one or more risk factors and are not suicidal. Other risk factors include: prior suicide attempt; family history of mental disorder or substance abuse; firearms in the home; incarceration; and exposure to the suicidal behavior of others, including family members, peers, or even in the media.

GENDER DIFFERENCES Suicide was the 8th leading cause of death for males and the 19th leading cause of death for females in 2000. More than four times as many men as women die by suicide, although women report attempting suicide during their lifetime about three times as often as men. Suicide by firearm is the most common method for both men and women, accounting for 57 percent of all suicides in 2000. White men accounted for 73 percent of all suicides and 80 percent of all firearm suicides.

CHILDREN, ADOLESCENTS & YOUNG ADULTS In 2000, suicide was the 3rd leading cause of death among 15-to-24-year-olds following unintentional injuries and homicide. Suicide was also the 3rd leading cause of death among children ages 10 to 15. The suicide rate for adolescents ages 15 to 19 was 8.2 deaths per 100,000 teenagers, including five times as many males as females. Among people 20 to 24 years of age, the suicide rate was 12.8 per 100,000 young adults, with seven times as many deaths among men as among women.

OLDER ADULTS Older adults are disproportionately likely to die by suicide. Comprising only 13 percent of the U.S. population, individuals age 65 and older accounted for 18 percent of all suicide deaths in 2000. Among the highest rates were white men age 85 and older, -59 deaths per 100,000 persons, more than five times the national U.S. rate of 10.6 per 100,000.

ATTEMPTED SUICIDES Overall, there may be between 18 and 25 attempted suicides for every suicide death; the ratio is higher in women and youth and lower in men and the elderly. Risk factors for attempted suicide in adults include depression, alcohol abuse, cocaine use, and separation or divorce. Risk factors for attempted suicide in youth include depression, alcohol or other drug use disorder, physical or sexual abuse, and disruptive behavior. As with people who die by suicide, many people who make serious suicide attempts have co-occurring mental or substance abuse disorders. The majority of suicide attempts are expressions of extreme distress and not just harmless bids for attention. A suicidal person should not be left alone and needs immediate mental health treatment.

PREVENTION Preventive efforts to reduce suicide should be based on research that shows which risk and protective factors can be modified, as well groups of people are appropriate for the intervention. In addition, prevention programs must be carefully tested to determine if they are safe, truly effective, and worth the considerable cost and effort needed to implant and sustain them. Many interventions designed to reduce suicide include treatment of mental and substance abuse disorders. Because older adults, as well as women who die by suicide, are likely to have seen a primary care provider in the year prior to their suicide, improving the recognition and treatment of mental disorders and other suicide risk factors in primary care settings may be one avenue to prevent suicides among these groups. Improving outreach to men at risk for suicide is a major challenge in need of investigation.

Recently, the manufacturer of the medication clozapine received the first ever Food and Drug Administration indication for effectiveness in preventing suicide attempts among persons with schizophrenia. Additional promising pharmacologic and psycho-social treatments for suicidal individuals are currently being tested. If someone is suicidal, he or she must not be left alone. Try to get the person to seek help immediately from his or her doctor or the nearest hospital emergency room, or call 911. It is also important to limit the person's access to firearms, medications, or other lethal methods for suicide.

COMMON QUESTIONS AND ANSWERS ABOUT SUICIDE What should you do if someone tells you they are thinking about suicide? If someone tells you they are thinking about suicide, you should take their distress seriously, listen non judgmental, and help them get to a professional for evaluation and treatment. People consider suicide when they are hopeless and unable to see alternative solutions to problems. Suicidal behavior is most often related to depression and/or to alcohol or other substance abuse. Suicidal behavior is also more likely to occur when people experience stressful events (major losses, incarceration). If someone is in imminent danger of harming himself or herself, do not leave the person alone. You may need to take emergency steps to get help, such as calling 911. When someone is in a suicidal crisis, it is important to limit access to firearms or other lethal means of committing suicide.

WHAT ARE THE MOST COMMON METHODS OF SUICIDE? Firearms are the most commonly used method of suicide for men and women, accounting for 60 percent of all suicides. Nearly 80 percent of all firearm suicides are committed by white males. The second most common method for men is hanging; for women, the second most common method is self-poisoning including drug overdose. The presence of a firearm in the home has been to be an independent, additional risk factor for suicide. Thus, when a family member or health care provider is faced with an individual at risk for suicide, they should make sure hat firearms are removed from the home.

HOW DO SUICIDE RATES COMPARE BETWEEN MEN AND WOMEN More than four times as many men as women die by suicide; but women attempt suicide more often during their lives than do men, and women report higher rates of depression.

WHO IS AT HIGHEST RISK FOR SUICIDE IN THE U.S.? There is a common perception that suicide rates are highest among the young. However, it is the elderly, particularly older white males that have the highest rates. And among white males 65 and older, risk goes up with age. White men 85 and older have a suicide rate that is six times that of the overall national rate. Some older persons are less likely to survive attempts because they are less likely to recuperate. Over 70 percent of older suicide victims have been to their primary care physicians within the month of their death, many did not tell their doctors they were depressed nor did the doctor detect it. This has led to research efforts to determine how to best improve physicians' abilities to detect and treat depression in older adults.

IS SUICIDE RELATED TO IMPULSIVENESS? Impulsiveness is the tendency to act without thinking through a plan or its consequences. It is a symptom of a number of mental disorders, and therefore, it has been linked to suicidal behavior usually through it's association with mental disorders and/or substance abuse. The mental disorders with impulsiveness most linked to suicide include borderline personality disorder among young females, conduct disorder among young males and antisocial behavior in adult males, and alcohol and substance abuse among young and middle-aged males. Impulsiveness appears to have a lesser role in older adult suicides. Attention deficit hyperactivity disorder that has impulsiveness as a characteristic is not a strong risk factor for suicide by itself. Impulsiveness has been linked with aggressive and violent behaviors including homicide and suicide. However, impulsiveness without aggression or violence present has also been found to contribute to risk for suicide.

IS THERE SUCH A THING AS "RATIONAL" SUICIDE? Some right-to-die advocacy groups promote the idea that suicide, including assisted suicide, can be a rational decision. Others have argued that suicide is never a rational decision and that it is the result of depression, anxiety and fear of being dependant or a burden. Surveys of terminally ill persons indicate that very few consider taking their own life, and when they do, it is in the context of depression. Attitude surveys suggest that assisted suicide is more acceptable by the public and health providers for the old who are ill or disabled, compared to the young who are ill or disabled. At this time, there is limited research on the frequency with which persons with terminal illness have depression and suicidal ideation, whether they would consider assisted suicide, the characteristics of such persons, and the context of their depression and suicidal thoughts, such as family stress, or availability of palliative care. Neither is it yet clear what effect other factors such as the availability of social support, access to care, and pain relief may have on end-of-life preferences. This public debate will be better informed after such research is conducted.

WHAT BIOLOGICAL FACTORS INCREASE RISK FOR SUICIDE?   Researchers believe that both depression and suicidal behavior can be linked to decreased serotonin in the brain. Low levels of serotonin metabolite, 5-HIAA, have been detected in cerebral spinal fluid in persons who have attempted suicide, as well as by postmortem studies examining certain brain regions of suicide victims. One of the goals of understanding the biology of suicidal behavior is to improve treatments. Scientists have learned that serotonin receptors in the brain increase their activity in persons with major depression and suicidality, which explains why medications that desensitize or down-regulate these receptors (such as the serotonin re-uptake inhibitors, or SSRIs)have been found effective in treating depression. Currently, studies are underway to examine to what extent medications like SSRIs can reduce suicidal behavior.

CAN THE RISK FOR SUICIDE BE INHERITED?   There is growing evidence that familial and genetic factors contribute to the risk for suicidal behavior. Major psychiatric illnesses, including bipolar disorder, major depression, schizophrenia, alcoholism and substance abuse, and certain personality disorders, which run in families, increase the risk for suicidal behavior. This does not mean that suicidal behavior is inevitable for individuals with this family history; it simply means that such persons may be more vulnerable and should take steps to reduce their risk, such as getting evaluation and treatment at the first sign of mental illness.

DOES DEPRESSION INCREASE THE RISK FOR SUICIDE?   Although the majority of people who have depression do not die by suicide, having major depression does increase suicide risk compared to people without depression. The risk of death by suicide may, in part, be related to the severity of the depression. New data on depression that has followed people over long periods of time suggests that about 2% of those people ever treated for depression in an outpatient setting will die by suicide. Among those ever treated for depression in an impatient hospital setting, the rate of death by suicide is twice as high (4%). Those treated for depression as inpatients following suicide ideation or suicide attempts are about three times as likely to die by suicide (6%) as those who were only treated as outpatients. There are also dramatic gender differences in lifetime risk of suicide in depression. Whereas about 7% of men with a lifetime history of depression will die by suicide, only 1% of women with a lifetime history of depression will die by suicide. Another way of thinking about suicide risk and depression is to examine the lives of people who have died by suicide and see what proportion of them were depressed. From that perspective, it is estimated that about 60% of people who commit suicide have had a mood disorder (e.g., major depression, bipolar disorder, dysthymia). Younger persons who kill themselves often have a substance abuse disorder in addition to being depressed.

DO ALCOHOL & OTHER DRUG ABUSE INCREASE THE RISK FOR SUICIDE?   Recent

surveys have shed light on the relationship between alcohol and drug abuse and suicidal behavior. A review of minimum-age drinking laws and suicides among youths age 18 to 20 found that lower minimum-age drinking laws were associated with higher youth suicide rates. In adults who drink alcohol, suicide ideation was reported among persons with depression. In another survey, persons who reported that they had made a suicide attempt during their lifetime were more likely to have a depressive disorder, and many also had a substance abuse disorder. In a study of all non-traffic injury deaths associated with alcohol intoxication, over 20% were suicides. Studies that examine risk factors among people who have committed suicide, substance use and abuse occurs more frequently among youth and adults, compared to older persons. For particular groups at risk, depression and alcohol use and abuse are the most common risk factors for suicide. Persons who are dependent on substances often have a number of other risk factors for suicide. In addition to being depressed, they are also likely to have social and financial problems. Substance use and abuse can be common among persons prone to be impulsive, and among persons who engage in many types of high risk behaviors that result in self-harm. There are a number of effective prevention efforts that reduce risk for substance abuse in youth, and there are effective treatments for alcohol and substance use problems. Researchers are currently testing treatments specifically for persons with substance abuse problems who are also suicidal, or have attempted suicide in the past.

WHAT IS "SUICIDE CONTAGION" AND WHAT CAN BE DONE TO PREVENT IT? Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, through media reports of suicide that may result in an increase in suicide and suicidal behavior. Direct and indirect exposure to suicidal behavior has been shown to precede a increase in suicidal behavior in persons at risk for suicide, especially in adolescents and young adults. The risk for suicide contagion as a result of media reporting can be minimized by factual and concise media reports of suicide. Reports of suicide should not be repetitive, as prolonged exposure can increase the likelihood of suicide contagion. Suicide is the result of many complex factors; therefore media coverage should not report oversimplified explanations of negative life events or acute stressors. Reports should not divulge detailed descriptions of the method used to avoid possible duplication. Reports should not glorify the victim and or imply that suicide was effective in achieving a personal goal such as gaining media attention. In addition, information such as hotlines or emergency contacts should be provided for those at risk for suicide. Following exposure to suicide or suicidal behaviors within one's family or peer group, suicide risk can be minimized by having family members, friends, peers, and colleagues of the victim evaluated by a mental health professional. Persons deemed at risk for suicide should be referred for additional mental health services.

IS IT POSSIBLE TO PREDICT SUICIDE? At the current time there is no definitive measure to predict suicide or suicidal behavior. However, there are identified factors to predict suicide or suicidal behavior. Identified factors that place individuals at higher risk for suicide, but not all persons with these risk factors will actually commit suicide. Risk factors include mental illness, substance abuse, previous suicide attempts, family history of suicide, history of being sexually

abused, and impulsive or aggressive tendencies. It is still difficult to predict which persons with these risk factors will ultimately commit suicide.

{jcomments on}