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September 2018 Newsletter

FLORIDA SUICIDE PREVENTION COALITION

*A statewide, grassroots organization
of survivors, crisis centers, & interested citizens*

ARE YOU A FSPC MEMBER?

Join FSPC, a statewide, grassroots organization of survivors, crisis centers, & interested individuals. Collaborate to advance suicide prevention efforts in larger numbers: get involved, volunteer with local & state FSPC activities, & obtain free or reduced registration at FSPC events. Membership information: <http://floridasuicideprevention.org/membership/>



FSPC NEWSLETTER SIGN-UP

Sign up to receive an email announcement when each Newsletter is posted on the FSPC website. Email Steve Roggenbaum, Vice Chair, at roggenba@usf.edu

SUPPORT FSPC WHEN YOU SHOP



You shop. Amazon gives.

Amazon donates to FSPC, when you make an online (at Amazon) purchase. Support FSPC by

going to smile.amazon.com and register the *Florida Suicide Prevention Coalition* (FSPC) as your chosen charity. So start shopping and support suicide prevention.

NEWSWORTHY

The National Suicide Hotline Improvement Act
By John Draper, PhD August 15, 2018 (AAS Listserv)
Executive Director National Suicide Prevention Lifeline & Executive Vice President of National Networks
Vibrant Emotional Health

On August 14th, the President signed into law *The National Suicide Hotline Improvement Act*, legislation that was introduced in the Senate by Senator Orrin Hatch and

Representative Chris Stewart, both from Utah. The Act authorizes a study be undertaken by SAMHSA, the VA and the FCC to explore the feasibility and impact of designating a 3-digit number (like 911, such as 611, etc.) for the Lifeline. The 3-digit number to be studied would be intended to assist persons with mental health and/or suicidal crises in the United States. The feasibility and impact study here will explore potential infrastructure needs to support such a service, resources needed to enhance its effectiveness, and the overall cost/benefits of such a service to public health and safety interests. The Act authorizes that the VA and SAMHSA independently collect data and information pertinent to the study over the next 6 months. In turn, each of these federal entities will file a report to the FCC in (or before) mid-February of 2019, and the FCC will continue to investigate the impact of such a service on communications systems and wireless carriers, as well as what 3 digit number should be recommended. On or before August 14th of 2019, the FCC will file a report to Congress, yielding recommendations compiled by SAMHSA, the VA and the FCC, for further actions. There are no appropriations tied to the current legislation.

Although this current legislation makes no promises for the Lifeline or our field, it still could be the most groundbreaking suicide prevention legislation for our country in years, perhaps having implications for the future at least as great as the Garret Lee Smith and Joshua Omvig Veterans Suicide Prevention Acts became laws over a decade ago. Just as those laws enjoyed unanimous bipartisan support, this Act has seen nearly the same level of agreement across party lines. Surely a factor in avoiding friction between parties was that this was an unfunded “study.” Nevertheless, many of the Bill’s co-sponsors in the Halls of Congress acknowledged the importance of suicide prevention and the need to promote access via an “easy-to-remember” number. In any case, the study assures that suicide prevention and the need to provide adequate support and access to national, state and local crisis care systems—in ways that are both efficient and effective—will be a part of conversations in Congress in ways that we haven’t seen in years (if ever).



Some of you may remember a time when there was no 911, and callers experiencing immediate threats to their health or safety desperately dialed “0”, imploring the operator to “connect me with the police” or “an ambulance!” Now begins a national conversation that could lead to a 3-digit number for mental health and suicidal crises that could one day be as ubiquitous in our grandchildren’s minds as 911 is to our urban, suburban and rural communities today.

I want to thank the vision of legislators from Utah and the tireless advocacy efforts of the American Foundation of Suicide Prevention—among others—for helping this legislation to become a part of our changing national conversation about suicide prevention. Above all, I want to thank our national network of crisis centers and their heroic staffs and volunteers who have been answering the record-breaking volume of Lifeline calls over the past year (and many years). The data and information that will be collected by the VA and SAMHSA over the coming six months will surely bear testament to the collective strength and sacrifices our networks have undertaken in service of people in crisis across this country, networks that have been collectively under-recognized and under-resourced for many years.

The Lifeline and our team at Vibrant Emotional Health in NYC look forward to working with SAMHSA, the VA and the FCC to gather the information needed for Congress to seriously consider future actions to enhance efficient and effective access to care for people in mental health and suicidal crises. These are interesting and important days for the field of crisis care and suicide prevention, indeed . . .

ALSO NEWSWORTHY

Rural Areas Have the Highest Suicide Rates and Fewest Mental Health Workers

By Eleanor Goldberg, Business Reporter, Huffington Post 06/18/2018

https://www.huffingtonpost.com/entry/rural-suicide-rates-mental-health_us_5b22dd28e4b0d4fc01fcc098

In the days and weeks following the suicides of celebrity chef Anthony Bourdain and handbag designer Kate Spade, a chorus of social media users urged people with depression to not be “afraid” to ask for help. But for most Americans, fear isn’t the thing that stands in the way of therapy. It’s having no one to turn to.

This was the case for Sue, 57, who spent over 30 years trying to get effective treatment for bipolar disorder, depression, anxiety and a personality disorder. For years, whenever Sue felt a major anxiety attack coming on, she’d panic. She would grab her keys, bolt out the door and frantically search for help. In rural Nebraska, that often meant walking up to two miles to the nearest neighbor’s house or emergency room, sometimes in the middle of the night.

Sue estimates that she’s been to the emergency room in crisis about 30 times. Staff members at the local hospitals she visited weren’t usually equipped to treat her and would typically send her home in a matter of hours.

Still, just having someone tell her she would be all right was enough of an incentive for Sue to return to the ER when her anxiety became too much to bear. “I ended up being released and going right back to the condition I was in,” she said. “I would do it again about a month later.”

There is a severe shortage of mental health workers across the U.S., but the problem is most pronounced in rural areas. There isn’t a single psychiatrist in 65 percent of nonmetropolitan counties, and almost half of those counties don’t have a psychologist, according to a report from the American Journal of Preventive Medicine released this month. Patients like Sue, who are desperate for care, will often turn to overburdened emergency rooms, which often don’t have the systems in place to help people with mental health issues.

“People with mental illness will present in the ER because they don’t know what else to do,” said Stephanie Knight, a licensed independent mental health practitioner and the administrative director at Fillmore County Hospital in Geneva, Nebraska.

But even when a rural area does have some mental health workers, they alone usually can’t address the entire population’s needs. Many residents are uninsured or underinsured, and can’t afford regular treatment. Residents may have to travel dozens of miles to get to the nearest town where a therapist works, and may not have access to transportation. Some therapists have irregular office hours and may only visit town a few days a month. The inconsistency can be a deterrent to patients.

Such was the case with Ann, 72, who lives in Crete, Nebraska. She has major depressive disorder and attempted suicide seven years ago. She enjoyed seeing a local therapist, but the therapist only came to her town once a month. “It was so infrequent,” Ann said. “After a couple of weeks, I’d think: ‘Why go back?’ There was no momentum.”

Rural areas have the highest suicide rates, according to the Centers for Disease Control and Prevention, as well as a high concentration of veterans, who experience higher rates of suicide than nonveterans. Rates of drug overdoses in rural areas have surpassed those in metropolitan areas. There are also more elderly people, who are often socially isolated and at risk for depression, said Ron Manderscheid, executive director of the National Association for Rural Mental Health.

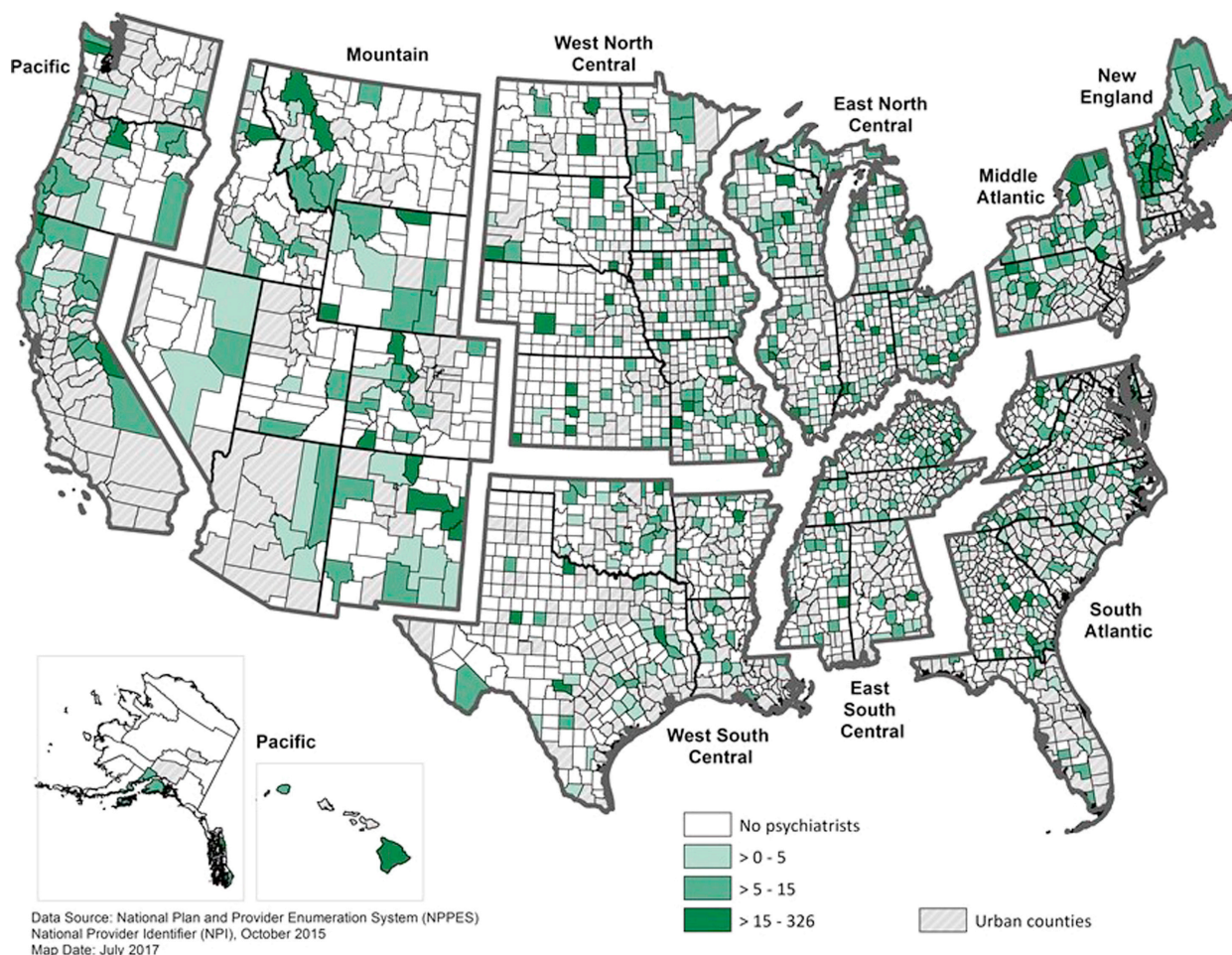
“If I went and looked at all those local communities, I will find a lot of socially isolated people. That is almost as deadly upon you as smoking,” said Manderscheid. “When you put that all together, rural areas are a pretty risky place for being at risk for suicide.”

Not enough people are going into the mental health field, and those in the field are aging, Manderscheid said. The average psychiatrist is in their mid-50s. Other specialists and primary care physicians are, on average, in their mid-40s. Those who do pursue careers in mental health typically find jobs in major cities.

“Historically, mental health has been an urban discipline,” Manderscheid added. “If you’re in New York, Chicago, San Francisco, Houston — any of our big areas — you will get the best mental health services we have to offer. If you’re in some of these rural areas, you won’t. It’s just as simple as that.”

While some government incentive programs help repay the student loans of therapists who work in underserved areas, many professionals don’t stick around once they’ve paid off their debts, Knight said. Manderscheid said improving telehealth programs, which allow patients to call or video chat with therapists in cities, is one potential solution. Encouraging young people from rural areas to go into the mental health field could also help.

“We need to start recruiting some of our providers from these rural areas, and work with people in high schools and colleges,” he said. “They are most likely to go back. They have an appreciation for rurality and living in rural communities.”



Knight, 35, grew up in rural Nebraska and struggled to get access to mental health services as a teenager. She had to travel 45 miles to see a therapist, who only had office hours until about 5 p.m. She’s now working on building a mental health program in Geneva, Nebraska, staffed by people who have a deep understanding and appreciation for rural America. Geneva’s population is just over 2,000 people.

There's a particularly pressing need for improved mental health programs in Nebraska, which faces longstanding staff shortages and federal funding cuts. Eighty-eight of Nebraska's 93 counties have behavioral health worker shortages, according to the Lincoln Journal Star, and the state has cut 200 inpatient beds at its three psychiatric hospitals since 2003. Knight said about a handful of psychiatrists serve rural Nebraska. The state didn't participate in the Medicaid expansion in 2013, which would've extended coverage to up to 80,000 residents.

When Knight and other hospital staff members started to lay the groundwork for the therapy program at Fillmore County Hospital in 2011, there was one behavioral health center in Geneva, served by therapists who rotated through the town and other parts of the state.

The program at Fillmore began with just Knight and a van driver to bring patients to the hospital. (They realized that in order to access the patients in greatest need, they would have to trek out to the farms and countryside to reach them.)

Now there are six therapists, most of whom grew up in rural areas. A physician writes an order for patients who are elderly and can no longer drive or who are on disability and can't afford transportation.

The van is a major expense that the hospital isn't reimbursed for, but it's a critical piece of the team's outreach efforts. The current vehicle already has over 200,000 miles on it and needs to be replaced, but a new one would likely cost \$150,000. The driver starts her route at about 6 a.m. and returns to the hospital at 10 a.m. with a handful of seniors who participate in group therapy.

Ann is one of the group members, and she lives about 80 miles away from the hospital. The three-hour round-trip journey is hard on her back, so she only participates once a week, even though her doctor recommended she receive treatment at least three times a week.

In 2013, in response to suicides, overdose cases and requests from community members, Fillmore expanded its mental health offerings and started building its inpatient program. Last month, the hospital saw 111 patients with mental health needs, not including people who are just being monitored for medication. In April, it had 39 new referrals, an "astronomical" amount for them, Knight noted.

The programs seem to be producing results. Sue, for example, just completed an outpatient therapy program at Fillmore on Wednesday after three and a half years. She hasn't been to the emergency room since 2015. When she has panic attacks, she turns to a host of coping mechanisms she's learned in therapy, including deep breathing and listening to music.

"I feel a sense of freedom," Sue said. "In recent times, I've done a really good job of getting my mind off the anxiety. It may take all day. It may take half an hour. I can do it without calling anyone."

If you or someone you know needs help, call 1-800-273-8255 for the National Suicide Prevention Lifeline. You can also text HOME to 741-741 for free, 24-hour support from the Crisis Text Line. Outside of the U.S., please visit the International Association for Suicide Prevention for a database of resources.

YET ANOTHER NEWSWORTHY ITEM

Florida Blue Health Innovation Pitch Competition Table Is Set, Seven from USF Among the Finalists By Keith Morelli *(abbreviated story below includes select & edited portions of original article)*

TAMPA (August 9, 2018) -- The table is set at the 2018 Florida Blue Health Innovation Pitch Competition.

The field of competitors was culled from 59 applicants representing 17 universities from across the state of Florida. In all, 28 finalists were chosen, forming 12 teams. Besides the seven finalists from the University of South Florida, pitch competitors come from a wide range of public universities, including Florida State, Florida Polytechnic, Florida Atlantic, Florida International, North Florida

and Central Florida. Students from private institutions Lynn University, Bethune-Cookman University, Gannon University and Nova Southeastern University also are signed up to take part in the competition.

"In the quickly evolving health care landscape, innovation and collaboration are imperative to find new ways to address health concerns," said David Pizzo, market president of Florida Blue's West Florida Region, which co-sponsors the pitch competition along with the USF Center for Entrepreneurship. "We see many of the growing health care trends of consumerism and increased use of personal technology integrated into the submissions of this year's finalists."

The finalists "offer a wide array of outside-the-box ideas to address the growing issue of depression and anxiety in America," he said. "We're eager to see how they are able to collaborate further with each other and their mentors over the next few months and present their innovations at the finals in October."

This is the seventh consecutive year the competition has been co-sponsored by Florida Blue and the USF Center for Entrepreneurship, said Michael Fountain, founder and director of the center.

"The event recognizes the top undergraduate and graduate health care innovators as they seek to develop solutions for one of the most pressing challenges facing health care today," he said, "addressing and managing anxiety and depression."



"Through the engagement of professional mentors, the student teams gain advanced insight into both the challenges faced by the health care professionals and insights in developing commercially viable products and services for the marketplace," Fountain said. "It is our hope that collaborations among business and health care professionals and students developed through this program will lead to meaningful solutions for our health care problems."

The finalists will pitch their ideas under the theme of anxiety and depression, a growing health problem many people face in today's rapidly changing and fast moving world. It's not a problem that discriminates, rather, it impacts all age groups, ethnicities, genders and professions. The American Psychological Association estimates 40 million American adults, 18 and older, have some type of anxiety disorder.

The applicants were told to focus on certain clinical groups, such as military service men and women, their families and significant others; current students, grief management, worker and family stress, people managing chronic and terminal diseases; and those dealing with end-of-life issues, cultural displacement, peer-pressure (bullying), pet grief, social media impact and others.

Those interested in competing were asked to come up with possible interventions or support mechanisms such as personal or group mobile applications, support networks, electronic platforms, virtual and augmented reality; physical activities programs, relaxation programs, stress-relieving mechanical or electronic devices, personal electronic physiological monitoring devices and others.

The competition – open to all undergraduate and graduate students at any college or university in Florida – takes place on Oct. 10 when finalists present their innovations to a panel of health care experts and executive representatives including Florida Blue. The event will be held at the GuideWell Innovation Center in Orlando's Lake Nona Medical City.

Among the finalists from the University of South Florida, ideas include:

Florida Blue pitch: to develop a mobile application with features that include a daily checklist for those with severe and chronic depression. The app also can be used to record symptoms and

provide patient/provider portals for electronic medical records and open communications lines. USF student is working with a student from Lynn University and Florida Polytechnic University.

Florida Blue pitch: to create web-based educational courses that provide resources and teach veterans about mental illness management techniques and coping skills. USF student is working with a student from the University of North Florida.

Florida Blue pitch: to come up with an app that compiles resources, proven anxiety management techniques and coping skills to provide users with all the information they need to conduct stress-free, rewarding lives.

Florida Blue pitch: to develop awareness and education programs for teenagers, drawing from various resources at NAMI. USF student is working with a representative from Gannon University, who is president of the Hillsborough NAMI chapter.

Florida Blue pitch: to create a product that alleviates breastfeeding-related stress in new mothers and helps postpartum depression.

Link to full story: <https://www.usf.edu/business/news/articles/180809-florida-blue-pitch-competition.aspx>

AVAILABLE RESOURCES (two resources from the same organization listed)

Guiding Their Way Back: A Resource For People Who Are Supporting Someone After A Suicide Attempt

Link: <http://s3-ap-southeast-2.amazonaws.com/everymind/assets/Uploads/Guiding-their-way-back.pdf>

For many people with health or mental health problems, most of the practical and emotional day-to-day support is provided by family and friends. The same is true for those who are recovering from a suicide attempt, yet partners, parents, sibling, friends, and colleagues are largely left unsupported.

In 2017, *Beyond Blue* in Australia released *Guiding Their Way Back: A Resource For People Who Are Supporting Someone After A Suicide Attempt*.

Sections include:

- Common reactions
- Talking about what has happened
- If you are worried that they are suicidal again
- Looking after yourself
- The future

An excerpt from the introduction:

This resource was developed with major input from many people who have attempted suicide and their family and friends; people just like you. It has been developed for ordinary, everyday people encountering the very difficult and intensely emotional time that occurs after a suicide attempt. The resource does not propose any one solution or path but provides information and thoughts based on shared experience and knowledge in the hope that your journey will be gentler and more informed.

The quotes used throughout this resource come from the people with lived experience of a suicide attempt who we spoke to in the development of the resource.

Finding Your Way Back: A Resource For People Who Have Attempted Suicide

Link: <http://www.beyondblue.org.au/thewayback>

Beyond Blue in Australia also released *Finding Your Way Back*. For those who have attempted suicide this resource may be of benefit.

Sections include:

- Getting immediate support
- Common reactions
- The people supporting you
- Talking about what has happened
- If thoughts about suicide return
- Looking after yourself
- The future

An excerpt from the document:

Getting your life back on track after attempting suicide is not easy. It takes time to recover, physically and emotionally. It is natural to have many feelings, thoughts and concerns. You might not know what to do or what to say.

This resource is a starting point for working through some of the questions that can come up after a suicide attempt. And it offers ideas about what may assist you in regaining a sense of control and to get back on track.

WHAT'S HAPPENING



September 3, 2018 (8-11 am), *NAMI Tallahassee's annual Bluebird Run & Walk for Brookie B.* J.R. Alford Greenway, 2500 South Pedrick Rd., Tallahassee.

<http://www.bluebirdrun.com/the-event/>

September 7-9, 2018, *National Weekend of Prayer for Faith, Hope, & Life* (National Action Alliance for Suicide Prevention) <http://actionallianceforsuicideprevention.org/faithhopelife>

September 10, 2018. *World Suicide Prevention Day.* Global activities.

September 9 - 15, 2018. *National Suicide Prevention Week.* <http://www.suicidology.org/about-aas/national-suicide-prevention-week>

September 2018. *National Suicide Prevention Month.*

September 22, 2018 (8:00 am – 11:00 am). *16th Annual Life; Story 5K/10K Run and Walk: For Depression Awareness and Suicide Prevention.* Nathan Benderson Park, Sarasota. <https://giving.centerstone.org/life-story/>

September 30, 2018 (3:00 – 6:45 pm). *Suicide Awareness Concert.* St. Augustine SDA Church, 458 Shores Blvd., St. Augustine. Lisa Zeller, FSPC Region 4 Director, is one of the event's speakers.

October 6, 2018 (10:00 am – 2:00 pm). *MindFest.* DeLand. <http://www.eccwestv.org/mindfest>

November 9, 2018 (7:00 am Breakfast; 8:00 am - 3:30 pm Conference). Miami-Dade Community College's *4th Annual Suicide Prevention Conference.* Nicklaus Children's Hospital - Main Auditorium, 3100 SW 62nd Avenue, Miami. <http://www.nicklauschildrens.org/cme>

March 19 & 20, 2019. **Save-the-Date:** *FSPC 2019 Fourth Annual Florida Taking Action for Suicide Prevention Conference* in Tallahassee. Info: <http://floridasuicideprevention.org/fspcevents/>

RESOURCES



If you or someone you know is in crisis, please call **1-800-273- 8255 (National Suicide Prevention Lifeline).**

Crisis Text Line – text “start” to **741-741**

Veteran's Crisis Line **1-800-273- 8255, press 1** & <https://www.veteranscrisisline.net/>

Resources for Survivors of Suicide Loss. SAVE. Suicide Awareness Voices for Education maintains a resource list at: <http://suicidegrief.save.org/ResourceLibrary>

Suicide Loss Survivors. The American Association of Suicidology (AAS) hosts a webpage with listed resources for survivors of suicide loss at <http://www.suicidology.org/suicide-survivors/suicide-loss-survivors>

Suicide Grief Resources. Helpful information, tools, and links for people bereaved by suicide at <http://suicidegriefresources.org/>

STOP Suicide Northeast Indiana. (2016). *Help & Hope: For Survivors of Suicide Loss.* Retrieved from <http://www.stopsuicidenow.org/toolkits-now-available/>

Florida's Statewide Office of Suicide Prevention (DCF):
<http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention>

National Action Alliance for Suicide Prevention: The Public-Private Partnership Advancing the National Strategy for Suicide Prevention:
<http://actionallianceforsuicideprevention.org/resources>

Coping After Suicide Loss: Tips for Grieving Adults, Children, and Schools. The American Psychological Association tip sheet. <http://www.apa.org/helpcenter/suicide-coping-tips.pdf>

Guide for Suicide Attempt Survivors after Treatment in the Emergency Department. The Substance Abuse and Mental Health Services Administration's (SAMHSA) brochure for people who have received emergency department treatment for a suicide attempt. Includes tips on how to cope with thoughts of suicide and resources for finding help. The brochure is also available in Spanish. <https://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Yourself-After-Your-Treatment-in-the-Emergency-Department/SMA18-4355ENG?utm>

Guide for Taking Care of a Family Member after Emergency Department Treatment for an Attempt. SAMHSA's brochure on caring for a family member after a suicide attempt which describes emergency department treatment process, lists questions to ask about follow-up treatment, and offers tips on how to reduce risk at home. The brochure is also available in Spanish. <https://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Your-Family-Member-After-Treatment-in-the-Emergency-Department/SMA18-4357ENG?utm>

Guide for Emergency Department Providers on Caring for Suicide Attempt Survivors. SAMHSA's brochure for emergency department providers on enhancing treatment for patients who have attempted suicide. It includes information on patient assessment, HIPAA regulations, and tips for communicating with family and other treatment providers. <https://store.samhsa.gov/product/A-Guide-for-Medical-Providers-in-the-Emergency-Department-Taking-Care-of-Suicide-Attempt-Survivors/All-New-Products/SMA18-4359?utm>

AN EXTRA HELPING . . .

My Dear Sister

by Steve Pollack, Hollywood Beach Suicide Survivor Support Group and volunteer meditation facilitator for Science of Spirituality

My dear sister, at the age of 25, took her own life in 1975. It was a huge shock to me, the entire family, as well as to her friends. It seems unlikely that anyone can ever get over a loss from suicide completely, though it gets easier to cope with the sad memories that fade a bit over the decades.

In the years following my sister's taking of her own precious life, I've grown through a lot of deep pain to develop some understanding of a few aspects of suicide that few ever get to see. That's

because I myself have had suicidal ideation numerous times. I was able to get a clear view of it from the inside out.

At the impressionable age of twelve, I saw my father talking openly with my mother and all five of us children about how he was considering taking his own life during a career crisis. He thought it was a way to provide for us financially by way of the major life insurance payments we'd receive. Fortunately, my father never did act upon that strategy to put us on Easy Street, though the very idea made a strong impression on me.

At the age of twenty, while I was at college, my big sister actually took that tragic escape route after her marriage fell apart. She was hell-bent on ending her life, and wouldn't listen to reason. Then it was no longer just a parent who had set the example of considering suicide openly, but an older sibling who actually completed a suicide. Two close family members I looked up to.

Suicidal ideation is defined as "thinking about or planning suicide. Thoughts can range from a detailed plan to a fleeting consideration. Most people who experience suicidal ideation do not carry it through, although some may make suicide attempts."

Fortunately for me, my ideation has been only a fleeting consideration from time to time, when I'm in a lot of anguish, frustration or other emotional pain that I can't readily see a way out of. I've never attempted suicide. Over time I find my way out of it, and I get a new lease on life.

People who've lost loved ones to suicide are often shocked, dazed and confused because their loved one rarely or never talked seriously about ending their life. Or if they mentioned suicide it may have sounded like a rhetorical remark or a joke. Many close family members and friends didn't see the actual suicide coming. Never in their worst nightmares did they imagine it would actually happen.

There's a reason for this dark secrecy around suicidal ideation. When I've talked to friends about my ideation, some brushed it off, and others felt terribly concerned and worried about me. I could see it disturbed them deeply. I was turning to them only for empathy, comfort and support, not to cause them worry or pain! I've talked about suicidal thoughts with a close family member like my brother, who never sought much support from anyone for the painful loss of our sister to suicide. He reacted with great alarm, frustration, worry, and even outrage. It grieved me to see how much pain this triggered in him when I simply confided in him. Again, I was reaching out only for compassion and for some understanding that I was going through an emotionally difficult time, but certainly not to cause any pain for my brother.

I realized that if someone close to me were worried or alarmed enough, they might take measures such as an intervention of some kind with all the best intentions to "save my very life." I could end up forcibly taken to a mental institution for observation, treatment, medication, etc. I certainly wouldn't want that to happen, so naturally I stop confiding in anyone who seemed so alarmed.

This is why so many are completely surprised when a suicide occurs with someone very close to them.

Another reason we are so shocked when someone actually completes a suicide is that we wonder why he or she didn't turn to us for help. We would have been there for them if they needed support, or so we believe with all our hearts.

The tragic fact is that many times, they did turn to us and talked about the issues they were struggling with. My sister begged her longtime childhood friend to let her come to visit her in Michigan as my sister was desperate. Her friend happened to be starting a new job and was too stressed to invite my sister to travel there.

Many of us live very busy, stressful lives. Even those who are not too busy were simply never trained in how to listen deeply with empathy and compassion to someone in need. We sometimes respond with a kneejerk reaction, which is to be alarmed, or to suggest a quick fix or some strategy

to address the issues. I was fortunate to learn the how-to's from books by Dr. Marshall Rosenberg, such as "Nonviolent Communication: A Language of Life." More information is freely available at www.cnvc.org.

Here are some typical unhelpful and helpful responses I've received when I mentioned to someone that my reactive mind was actually trying to figure out a feasible way to end my life. I'm not judging people for responding without using the language of compassion--many people simply don't know how because they've never studied it. Not everyone would agree with the categories I've assigned to each and every response, these are just how they struck me personally.

UNHELPFUL RESPONSES:

- I don't know what to say, Steve, you know last year I was thinking about ending it myself because life is rough sometimes and you just have to buck up and roll with the punches. I'm busy, sorry, I've gotta go now.
- You're just too sensitive; Steve, and you analyze things too much. Grow a thick skin and don't let things get to you so much.
- You and me both, Steve, let's shoot each other. By the way, did you try that new restaurant down the street?
- You're not serious about that, are you? If you are, you should go and see a shrink immediately because that's just crazy!
- If you kill yourself, I'll never forgive you!! Get that thought out of your head, don't even think about it!
- Suicide is a coward's way out. Grow a pair and deal with your life, after all we all know life is painful.
- You know that your soul will only go to a dark place, maybe even to hell, all the religions say that's what happens. Do you really want to risk that?
- I'm not even going to listen to this nonsense, it's ridiculous because you have such a good life! Stop whining!
- Get yourself some anti-depressants. You may feel a bit cloudy in the head, but at least you won't think about ending your life.
- You're scaring the crap out of me right now, should we do some kind of intervention to protect you?

HELPFUL RESPONSES:

- It sounds to me like you're actually serious about this...I get off work in a few hours, if you want to talk about it then, I'm here for you.
- I lost a friend to suicide years ago, which was so painful and I'd hate to lose you; your friendship and support have meant so much to me over the years I've known you.
- Is there anything at all I can do to help? I can be a good listener if that's what you need.
- Hearing you say that, I feel concerned because you've never mentioned those feelings to me before. Can you reassure me that you'll be okay? Mind if I call you over the next few days just to check in or to talk?
- Are you feeling depressed long-term or just upset about something that happened recently?
- I know of a support group for people who've struggled with depression or suicidal ideation, would you like more information?

- It must be really painful and difficult for you right now to be having such strong feelings about your life and about life itself, to be questioning its value . . .

Depression creates a sort of tunnel vision that narrows a person's perceptions of reality. Once a sense of disgust, hopelessness or helplessness sets in, people can begin to withdraw emotionally from even those who love them most. They may be physically around or nearby every day, and folks assume all is well, but emotionally the depressed person is withdrawing slowly into their own private hell. The pain comes from hopelessness, emotional exhaustion, desperation, frustration, and sadness, to name just a handful.

Another reason we may be flabbergasted by a suicide is our inability to understand why the depressed person didn't seek professional help. There are so many reasons for this. Some families, such as mine, believed that therapy was for very, very rich people who were weak or whiny and couldn't find a good friend to talk their heart out to. A depressed person may have had some less than helpful experiences with therapists. She or he may have felt afraid to confide in another counselor who might not fully understand, who might pressure them to take medications or possibly even institutionalize them against their will.

Finally, we may tend to wonder why the person took the extreme measure of killing herself or himself. Why didn't they just take a vacation or run away or go visit someone they love or take euphoric, pain-killing drugs or do anything to change the scene...why resort to killing? It just doesn't make sense to someone who has never had suicidal ideation.

Here's how I explain it. When we watch a spy movie or read a novel, a protagonist might be a secret agent who gets caught by the enemy and takes a poison capsule to avoid a life in jail or years of extreme torture. It's tragic, yes, but we don't question it much. We accept that a quick and painless death would probably be much easier than to be banned to Siberia for years of frozen isolation, hard labor, brainwashing, or torture.

When depression progresses undiagnosed and unaddressed* for years, it can become every bit as agonizing as a life sentence in a Siberian torture chamber or prison. The enemy that captures us is the negative mind. The depressed person, when he thinks there is no way to get out of that torture chamber, when he feels the depths of hopelessness and despair, pain and frustration, believing it will never get any better, reaches for a gun, a razor blade or a bottle of pills. Or he finds a high perch to jump off of. He truly believes he wants to die.

Many people who have survived jumping off a bridge into the water below found that the moment they jumped, they regretted that decision. They wanted another chance to live, but for most, it was too late.

I don't believe anyone ever really wants to die, certainly not at their own hand. They just want to end the emotional pain that appears to have no end in sight.

I've discovered that for myself (not necessarily for anyone else) meditation gives me the opportunity to "die while living." In fact, that's a phrase created by some of the great Eastern mystics who believe the goal of spiritual growth is to learn how to die while living. Meditation gives me a healing rest from the stressful thoughts and emotional pains of this complex physical world. I'm able to rise above the muck and mire of dark emotions, of life's disappointments and frustrations. I enjoy the benefits of "dying" for an hour or so when I enjoy being in the blissful inner light, and I can always come back to physical consciousness and pick up where I left off. When I come out of meditation, I feel a sense of profound peace, rest, and rejuvenation, even happiness at times. Sometimes the upliftment is so strong as to give a sense of joy or bliss. I'll take that over a plunge off the Golden Gate Bridge any day. Many people are glad that I've made this choice, to live.

Author's Note: Traditional psychotherapy is one way to address or treat depression, which often includes drugs, but it's certainly not the only way. There are several alternative ways to address it without drugs. Either way,

there are no guarantees. Someone may complete suicide even while in treatment with a therapist and taking anti-depressants as prescribed. Some may complete suicide while trying alternative therapies and strategies. It would be interesting to see if there are accurate studies showing the various success rates of the different avenues.

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