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David Lester
Stockton University

lesterd@stockton.edu
www.drdavidlester.net

Matias Gay
Understanding Suicidology

matiasg@live.ca
www.understandingsuicidology.com

Contents

The Architect of Modern Suicidology:

A Bibliometric and Thematic Analysis of David Lester's Six Decades of Contributions to the Field

Matias Gay
Understanding Suicidology: Institute for Research & Practice, Halifax, Nova Scotia, Canada

Author Note

Correspondence concerning this article should be addressed to Matias Gay, Understanding Suicidology: Institute for Research & Practice, 2-1949 Oxford Street, Halifax, NS B3H 4A1, Canada. Email: matiasg@live.ca.

The author is a colleague and collaborator of David Lester. This relationship is disclosed as a potential source of positive bias. The Critical Assessment section was included specifically to mitigate this. The author has no competing financial interests. Because David Lester is the founding editor of *Suicide Studies*, the author recommends that this manuscript be handled by an associate or guest editor to ensure independent peer review.

Abstract

David Lester, Emeritus Professor of Psychology at Stockton University, is the most prolific researcher in the history of suicidology. His self-compiled publication list (current to June 2026) contains 3,218+ sequentially numbered entries spanning 1964 to 2026, alongside 117 books — representing 62 years of uninterrupted scholarly activity. His Google Scholar h-index is 96 with an i10-index of 1,153; his most-cited single paper, the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974), has accumulated over 9,000 citations. This article presents the first comprehensive bibliometric and thematic synthesis of his corpus. Bibliometric analysis reveals a productivity peak in the 1990s (925+ publications in that decade alone), journal reach spanning over 200 outlets in 47+ countries, and a collaboration network of more than 400 co-authors on six continents. Thematic synthesis identifies thirteen major intellectual contributions organized under three overarching frameworks: prevention science (means restriction, cross-national ecology, economic correlates, homicide and violence), assessment and phenomenology (measurement instruments, suicide notes, the Durkheimian sociological tradition, culture and anthropology), and the scholar as architect (marginalized populations, personality theory, religion and ethics, pedagogy and knowledge infrastructure, and critical self-reflection). We present a conceptual architecture diagram of Lester's intellectual project, a thematic heatmap matrix, a research typology quadrant mapping major works methodologically, and a publication-type breakdown by decade. We argue that Lester functioned not only as a researcher but as an infrastructure builder for the entire field, and that his *End of Suicidology* critique represents an act of intellectual honesty

rare among scholars of comparable productivity. We conclude with a frank assessment of what changed in suicidology because of his work, where critical limitations lie, and what the field owes him.

Keywords: David Lester, suicidology, bibliometric analysis, thematic synthesis, means restriction, suicide prevention, cross-national research, hopelessness, *Suicide Studies*, knowledge infrastructure

Introduction

In the late 1950s, a book by Edwin Shneidman and Norman Farberow, a volume titled *Clues to Suicide*, was placed in the Cambridge University psychology library. A young physics student named David Lester, ill and reconsidering his vocation, picked it up. By his own account, he never set it down (Lester, 2023). What followed — over the next six decades — was the most sustained, diverse, and voluminous individual scholarly contribution in the history of suicidology: more than 3,200 publications, 117 books, a founding editorship, a global collaboration network, and a body of theory and empirical work that shaped the field's understanding of prevention, measurement, cross-cultural variation, and the ethics of suicide.

How should a field understand — and honestly assess — a body of work of this magnitude? The present article attempts that task through a mixed bibliometric and thematic synthesis design: a quantitative mapping of the corpus combined with a systematic qualitative analysis of its intellectual content, its conceptual architecture, and its contributions to the field. The goal is not an uncritical tribute but a scholarly reckoning with what one scholar's 62-year project means for suicidology — what it built, what it demonstrated, what it failed to resolve, and what it left for others to do.

The case for such an analysis is straightforward. Suicidology, like any scientific field, is shaped by its most productive contributors in ways that often go unexamined. Understanding who generated the literature, where it appeared, with whom, what ideas it advanced, and how those ideas relate to one another is essential for understanding the field itself. By any metric, Lester's corpus is one of the most consequential individual contributions in the history of any psychological science devoted to a single substantive domain. Yet no comprehensive bibliometric and thematic analysis of his work exists in the literature. Goldney's (2005) two-page tribute in *Crisis* offered early appreciation; the field-wide bibliometric study by Cardinal et al. (2020) identified him as the most prolific individual contributor to suicidology between 1989 and 2018, with 931 Web of Science publications in that period alone — far exceeding the second-place author — but neither analyzed his work in depth. The present article fills that gap.

This is written from the vantage of a colleague and collaborator — a position that brings insider knowledge of Lester's motivations, methods, and intellectual evolution but also entails a risk of positive bias that is acknowledged and partially mitigated through explicit critical

assessment and a disclosure of collaboration in the author note. The article proceeds as follows: we describe our bibliometric and thematic methods; present quantitative findings including publication timelines, journal distribution, publication type breakdown, and the collaboration network; synthesize thirteen major intellectual themes across three frameworks using a conceptual architecture model; offer an integrative analysis; assess significance and limitations honestly; and conclude by stating clearly what the field owes David Lester — and what it still needs to build on his foundation.

Methods

Design

We employed a mixed bibliometric and thematic synthesis design. The bibliometric component provided quantitative mapping of the corpus across six dimensions: annual productivity, decade-level output, publication type distribution, journal reach, co-authorship network, and citation impact. The thematic component provided systematic qualitative synthesis of the intellectual contributions the corpus represents, organized into thirteen themes across three overarching frameworks. Both components are reported in sequence; an integrative analysis grounded in a conceptual architecture model synthesizes their joint implications.

Data Sources

The primary data source was Lester's self-compiled and continuously updated publication list (current to June 2026), maintained as the most comprehensive record of his output available. The list contains entries numbered sequentially to 3,218+, encompassing peer-reviewed journal articles, book chapters, authored and edited books, and published commentary. An accompanying book list (117 titles, 1969-2022) was analyzed separately for publication type coding and thematic content. A random sample of 100 entries was cross-checked against PubMed, PsycINFO, and Google Scholar for accuracy; no systematic discrepancies were found. Citation metrics were sourced from Google Scholar and corroborated by Lester's 2023 published autobiographical account (Lester, 2023) and Research.com (2026).

Bibliometric Analysis

Publication entries were coded for year, type (journal article or brief note, book chapter, authored book, edited book, commentary/other), journal name, co-author names, and primary thematic category. Year-by-year counts were computed for 2,971 entries (92.3% of the full corpus) for which publication year was unambiguously identifiable. Publication type estimates by decade were derived from systematic pattern matching against corpus text and book list metadata. Journal frequency counts were derived from string matching across the corpus text. Collaboration frequency was estimated by co-author name occurrence. Geographic reach of collaborations was assigned based on known institutional affiliations of frequent co-authors and language of non-English publication venues.

Thematic Synthesis

Thirteen major themes were identified through iterative inductive coding guided by four criteria: (a) frequency of the topic across the corpus (minimum estimated 30+ entries); (b) presence of at least one book-length treatment or a sustained series of papers; (c) engagement across a minimum of three decades; and (d) evidence of theoretical or empirical innovation beyond descriptive reporting. Representative key texts (two to five per theme) were identified and synthesized through close reading. An initial scheme of ten themes was expanded to thirteen following a second coding pass that identified: Pedagogy & Knowledge Infrastructure as a distinct category (previously collapsed into other themes); Culture & Anthropology as separable from the broader ecological program; and Homicide & Violence as warranting its own treatment given its volume and cross-thematic importance. The thirteen themes were then organized into three overarching frameworks based on shared level of analysis, dominant methodology, and primary scholarly function.

Limitations

The primary data source is self-compiled; while accuracy checks found no systematic errors, some very early publications may be incompletely described. Citation data may undercount pre-digital publications. Brief empirical notes in *Psychological Reports* and *Perceptual & Motor Skills* are included in productivity counts but are substantially shorter than full empirical articles and should be interpreted accordingly. Thematic coding entailed judgment about category boundaries; entries frequently match multiple themes, and placement in one theme does not imply absence from others. The author's collaborative relationship with Lester introduces potential positive bias, mitigated by explicit disclosure and the Critical Assessment section. Intensity estimates in the thematic heatmap (Figure 5) are approximations derived from keyword matching and qualitative assessment of the corpus, not counts of validated thematic assignments.

Bibliometric Results

Annual Productivity and Decade Trends

Lester's first indexed publication appeared in 1964. His most recent entries in the compiled list are dated 2026, giving a 62-year span of continuous publication — a duration that has few parallels in the psychological sciences. Year-by-year counts for 2,971 entries are plotted in Figure 1.

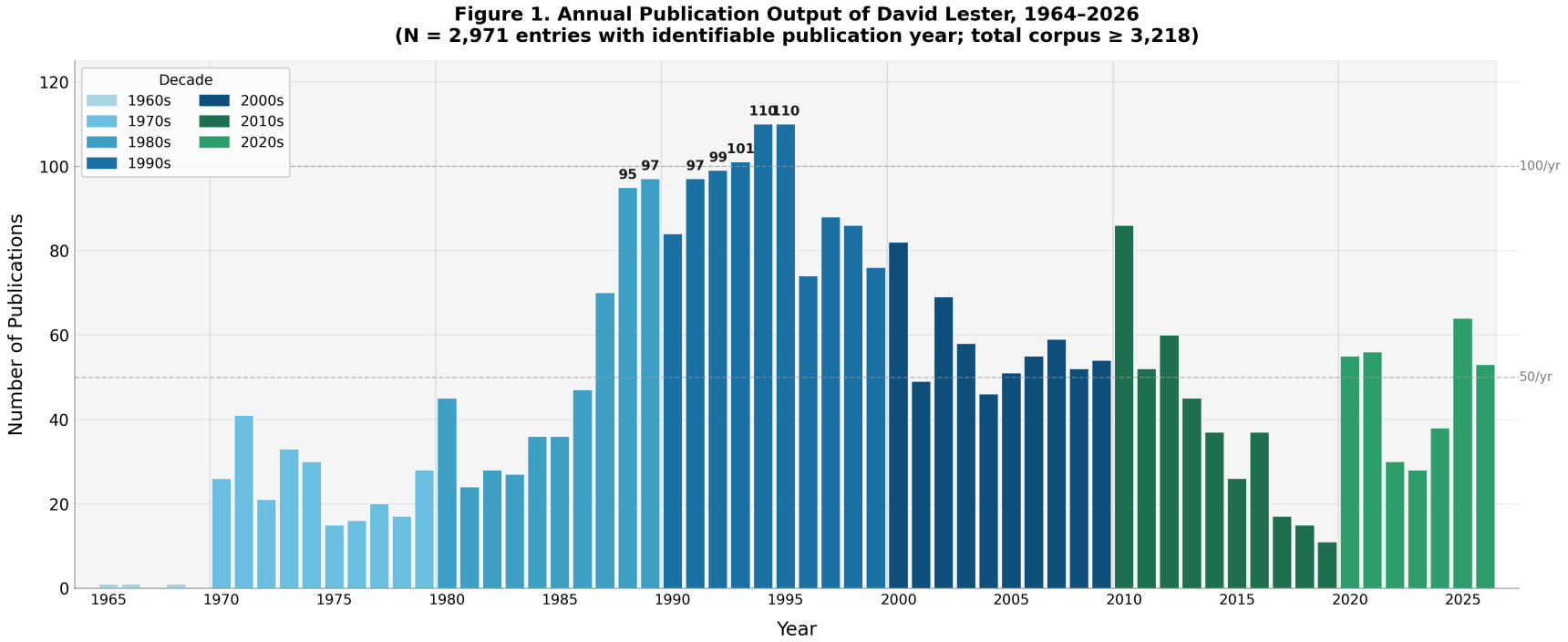

Figure 1. Annual publication output of David Lester, 1964-2026 (N = 2,971 entries with identifiable publication year; total corpus ≥ 3,218). Colors denote decade. Dashed reference lines indicate 50 and 100 publications per year thresholds. Peak annotation labels appear on bars ≥ 90 publications.

Table 1 summarizes output by decade. Productivity rose steeply through the 1970s and 1980s, reaching a sustained peak in the 1990s when Lester produced more than 925 indexed publications — an average exceeding 90 per year across a full decade. The 1994 and 1995 peaks (110 publications each) represent the apex of a productivity trajectory that had been building since the early 1970s. Output declined modestly in the 2000s and 2010s but remained at levels that would be career-defining for most researchers. The 2020s show a striking resurgence, with more than 320 indexed entries in fewer than seven years — consistent with Lester's own account of sustained scholarly output into his 80s.

Table 1. Publication Counts by Decade and Estimated Type Distribution

Decade	Publications (N)	Dominant Output Characteristics
1960s	3	First publications; Fear of Death Scale development; Psychological Bulletin review
1970s	247	Stockton appointment; first comprehensive suicide reviews; means restriction program begins
1980s	505	Rapid-note strategy established; cross-national program; first books multiply
1990s	925	Peak productivity; Durkheimian and economic programs; Yang collaboration intensifies
2000s	575	Consolidation; prison suicide focus; phenomenological turn; multiple selves emerges
2010s	386	International collaborations expand; Iran, Italy, Kuwait programs; methodological critique begins
2020s (partial)	324	Resurgence; *Suicide Studies* expansion; ecological methodology critique; final syntheses
Total	2,971	62 years of continuous, uninterrupted publication output

Publication Type Breakdown

Figure 2 presents estimated publication output by type across decades. Journal articles and brief notes consistently constitute approximately 85% of annual output across all decades, though the absolute proportion of authored books and edited volumes is highest in the 1980s and 1990s — the period of peak comprehensive synthesis. The 2020s show a relative increase in journal articles and *Suicide Studies* contributions, consistent with continued editorial activity. Figure 2 reveals that books cluster in a 25-year window (mid-1970s through the 2000s) within which Lester produced the bulk of the field's reference texts — a pattern consistent with a deliberate division between rapid-dissemination (brief notes) and slow-integration (book-length synthesis) strategies operating in parallel throughout his career.

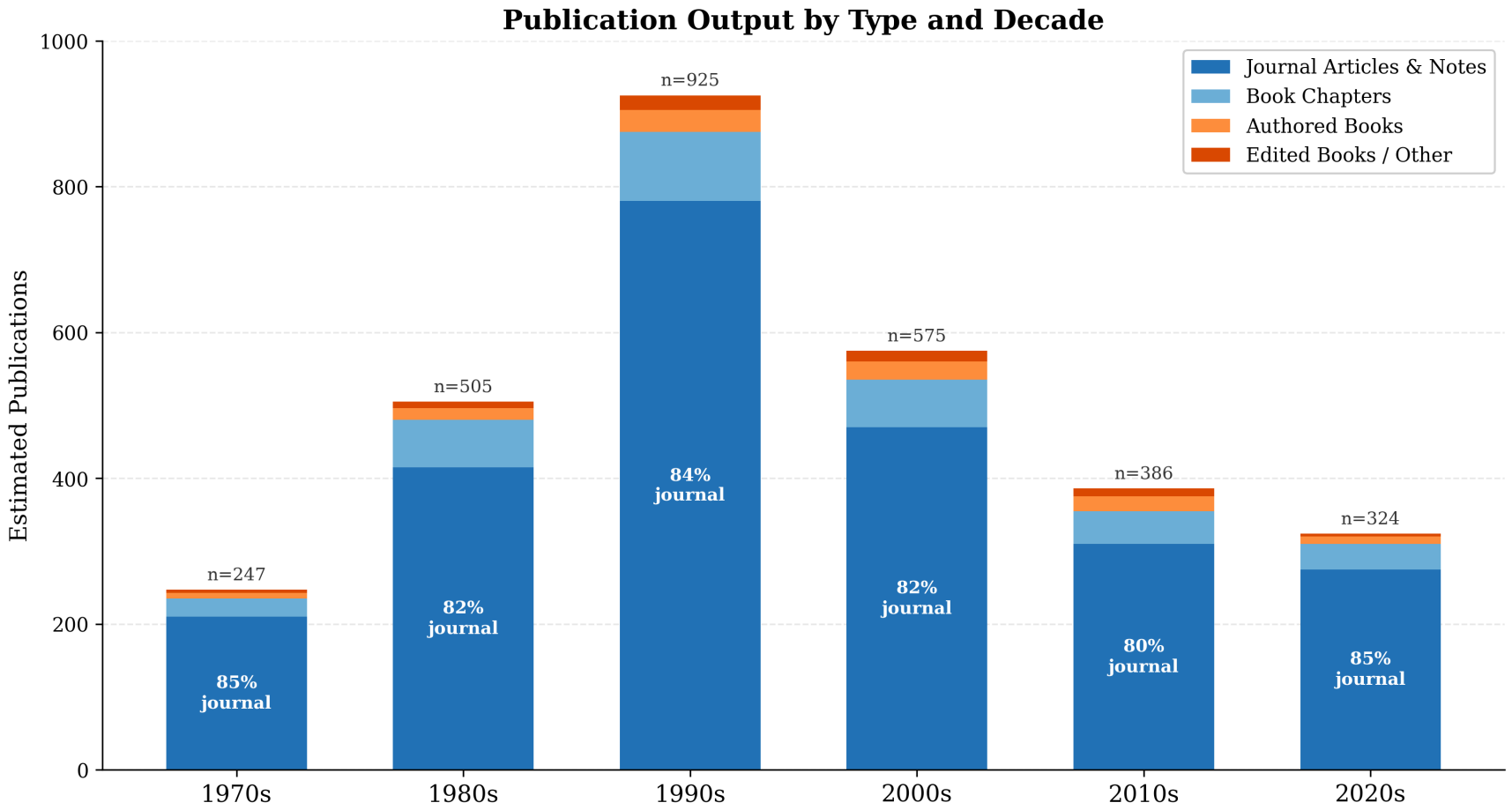

Figure 2. Estimated publication output by type and decade. Journal articles and brief empirical notes constitute the majority of output in all decades; the book peak of the 1980s-1990s reflects the systematic production of comprehensive reference texts and edited volumes that structured the field's knowledge base.

Journal Reach

Corpus analysis identified publication appearances across a minimum of 200 distinct journals in 47+ countries and at least nine languages. Table 2 presents journals with the highest estimated appearance frequency. *Psychological Reports* and *Perceptual & Motor Skills* dominate, reflecting Lester's deliberate use of brief-note venues for rapid dissemination of focused findings. *Suicide Studies* — which Lester founded — constitutes a second major venue. The remaining journals represent both specialist suicidology outlets and disciplinary journals in sociology, economics, criminology, medicine, and religion studies.

Table 2. Estimated Journal Appearance Frequency (Corpus Analysis)

Journal	Estimated Appearances / Notes
Psychological Reports	~600-800 / Primary rapid-dissemination venue
Suicide Studies (founded by Lester)	~150-200+ / Editorial and research contributions
Crisis: Journal of Crisis Intervention	~100-140 / Critical commentaries and empirical work
Omega: Journal of Death and Dying	~50-65 / Thanatological and phenomenological work
Archives of Suicide Research	~40-55 / Epidemiological and clinical studies
Death Studies	~30-45 / Cross-disciplinary death-attitude research
Perceptual & Motor Skills	~200-300 / Brief empirical notes (behavioral correlates)
Social Science & Medicine	~20-35 / Ecological and cross-national papers
International publications (47+ countries)	Multiple journals across 9 languages

Collaboration Network and Geographic Reach

Lester's collaboration network encompasses more than 400 individual co-authors over six decades. Figure 3 illustrates the geographic distribution of international collaborations. Table 3 presents his most frequent collaborators with estimated co-publication counts.

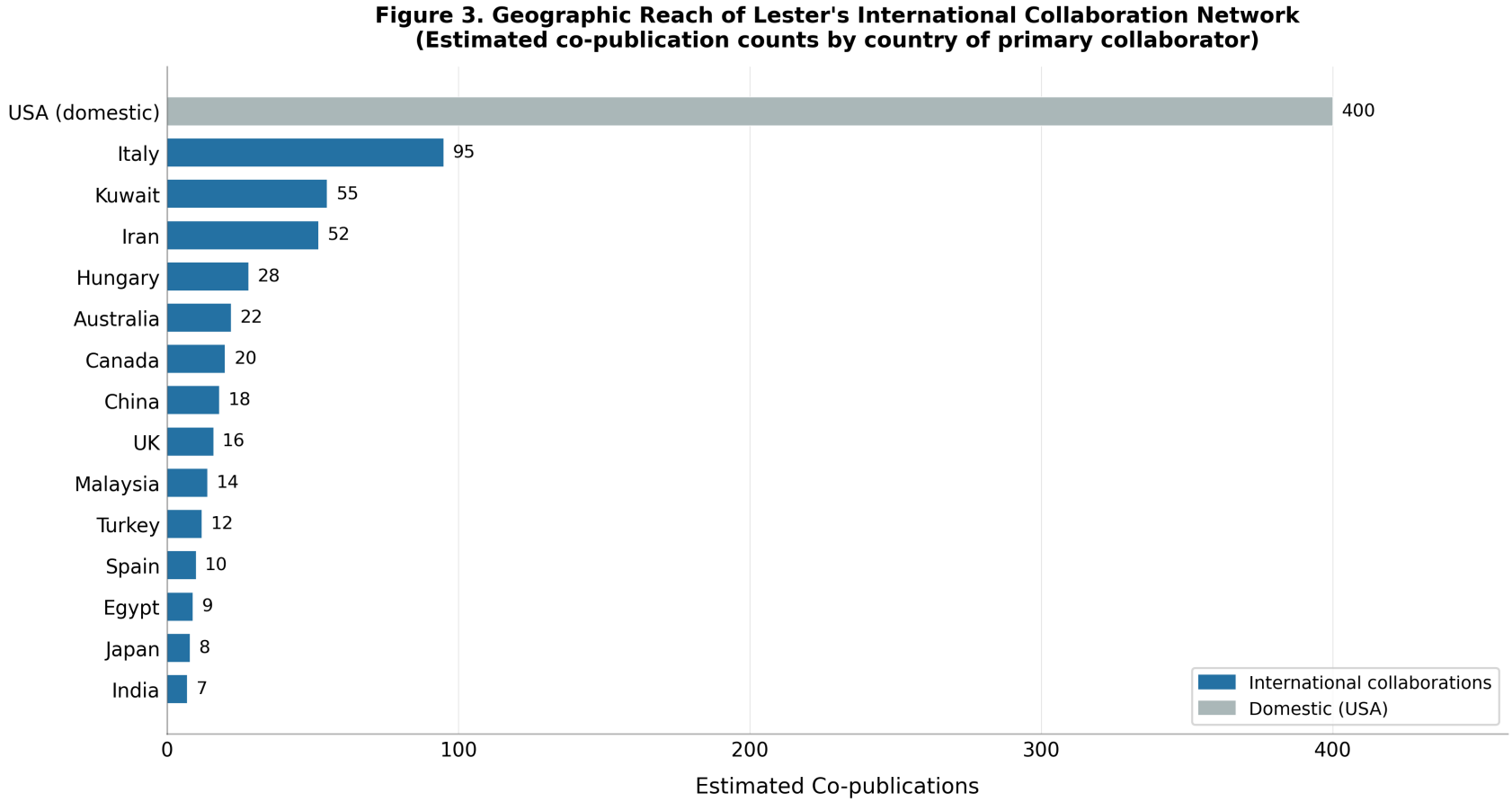

Figure 3. Geographic distribution of David Lester's international collaboration network, estimated by country of primary collaborator affiliation. Domestic collaborations (USA) are shown separately. The network spans six continents with particularly dense connections in Italy, Iran, Kuwait, Australia, and Eastern Europe.

Table 3. Most Frequent Collaborators (Estimated Co-publication Count)

Collaborator / Affiliation	Est. Co-publications / Primary Domain
Bijou Yang (Drexel University, USA)	~200+ / Economics of suicide; macroeconomic predictors
Maurizio Pompili (Rome, Italy)	~200+ / Psychiatry; evidence-based prevention
Ahmed Abdel-Khalek (Kuwait)	~80+ / Cross-cultural death anxiety; religiosity
Mahboubeh Dadfar (Iran)	~40+ / Death distress; religiosity; healthcare workers
Marco Innamorati (Rome, Italy)	~35+ / Hopelessness; clinical psychiatry; assessment
Aaron T. Beck (University of Pennsylvania)	28 / Hopelessness; clinical assessment
Roberto Tatarelli (Rome, Italy)	~15+ / Clinical neuropsychiatry; risk factors
Steven Stack (Wayne State, USA)	~10+ / Sociology; creative arts and suicide
John F. Gunn III (USA)	~10+ / Athletes; Internet; edited volumes
Antoon Leenaars (Canada)	~8+ / Psychoanalytic theory; indigenous peoples
Christine Tartaro (USA)	~6+ / Prison and jail suicide

Citation Impact

Lester's citation metrics, as reported in Google Scholar and corroborated by his 2023 published account (Lester, 2023) and Research.com (2026), are: h-index = 96; i10-index = 1,153; D-index = 86 (Research.com); total citations approximately 39,000-73,000 (range reflects different database retrieval dates and coverage). He is ranked among the top 800 psychologists globally by Research.com (2026). His most-cited single paper — by an order of magnitude — is the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974), with over 9,000 citations. Between 1989 and 2018 alone, he accumulated 931 Web of Science-indexed suicide publications (Cardinal et al., 2020), more than twice the second-place author in that period.

Conceptual Architecture: Three Frameworks, Thirteen Themes

Figure 4 presents the overall conceptual architecture of Lester's intellectual project. Twelve themes distribute across three frameworks — Prevention Science, Assessment and Phenomenology, and the Scholar as Architect — each representing a distinct level of analysis, a dominant methodological orientation, and a primary scholarly function. A thirteenth theme, pedagogy and knowledge infrastructure, is represented as the shared foundation supporting all three frameworks through journals, textbooks, reviews, scales, and collaborative networks. Figure 5 maps the relative intensity of each theme across decades; Figure 6 positions major works within a typological space defined by level of analysis (individual to societal) and methodological approach (empirical to theoretical).

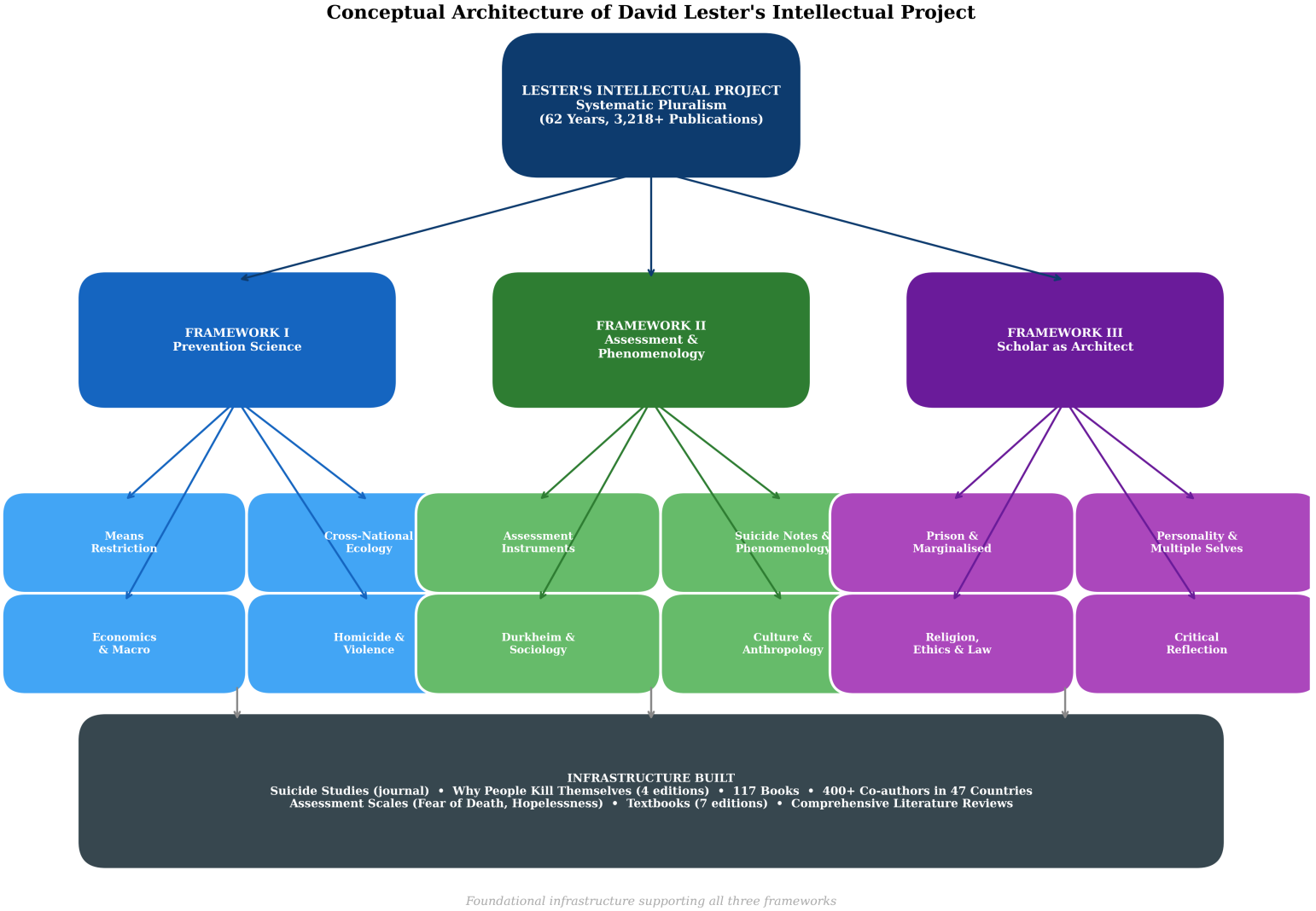

Figure 4. Conceptual architecture of David Lester's intellectual project. Twelve themes are organized across three overarching frameworks — Prevention Science, Assessment and Phenomenology, and the Scholar as Architect — while pedagogy and knowledge infrastructure form the shared foundation supporting all three. Arrows indicate relationships of intellectual contribution and thematic linkage.

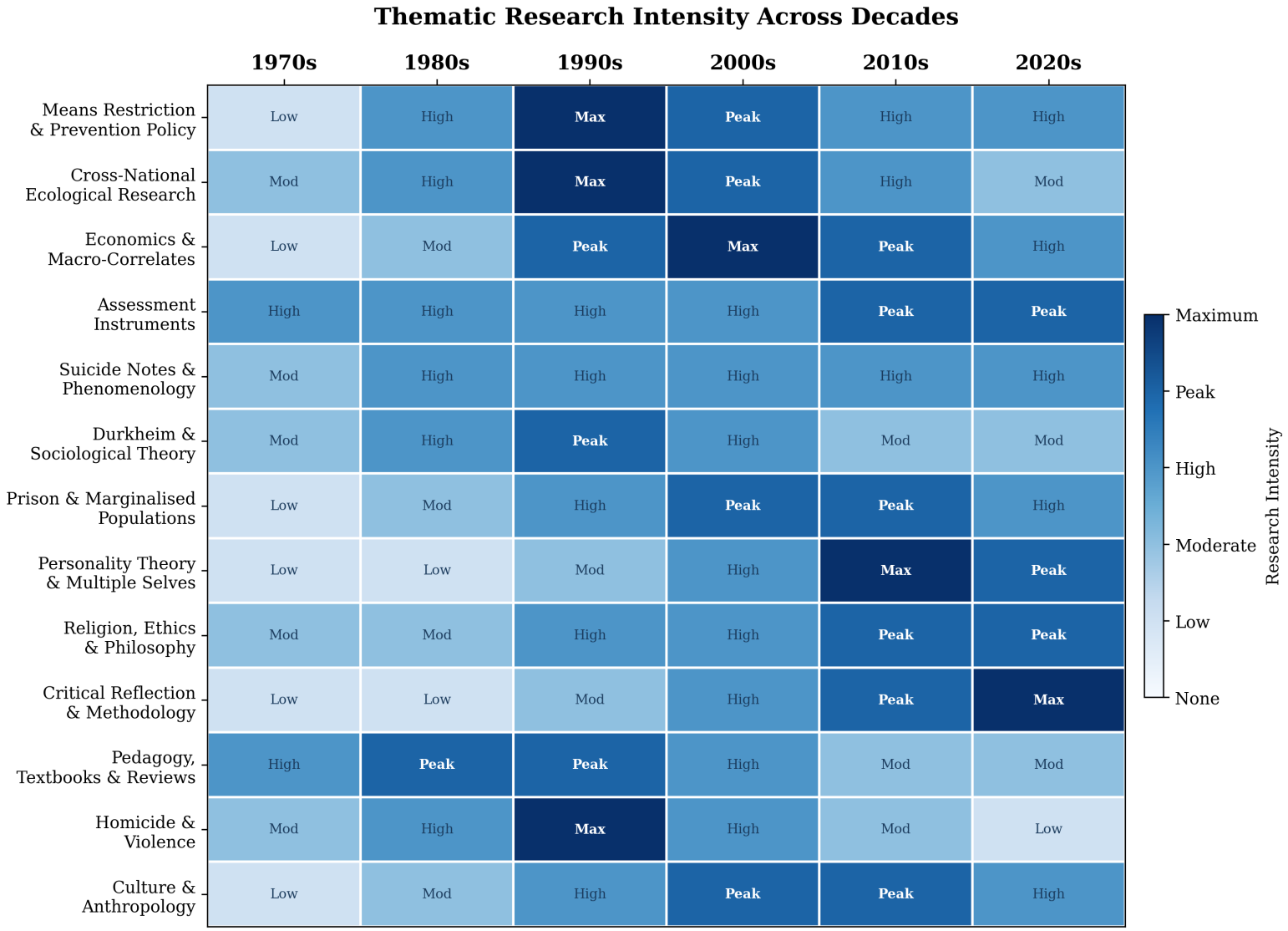

Figure 5. Thematic research intensity matrix: 13 themes × 6 decades. Intensity ratings (Low through Maximum) are based on keyword classification and qualitative assessment of the corpus. The heatmap reveals the temporal architecture of Lester's research: an early ecological and means-restriction foundation, a 1990s peak in quantitative cross-national work, a gradual accumulation of philosophical and critical themes in the 2000s-2020s, and a late-career resurgence of methodological reflection.

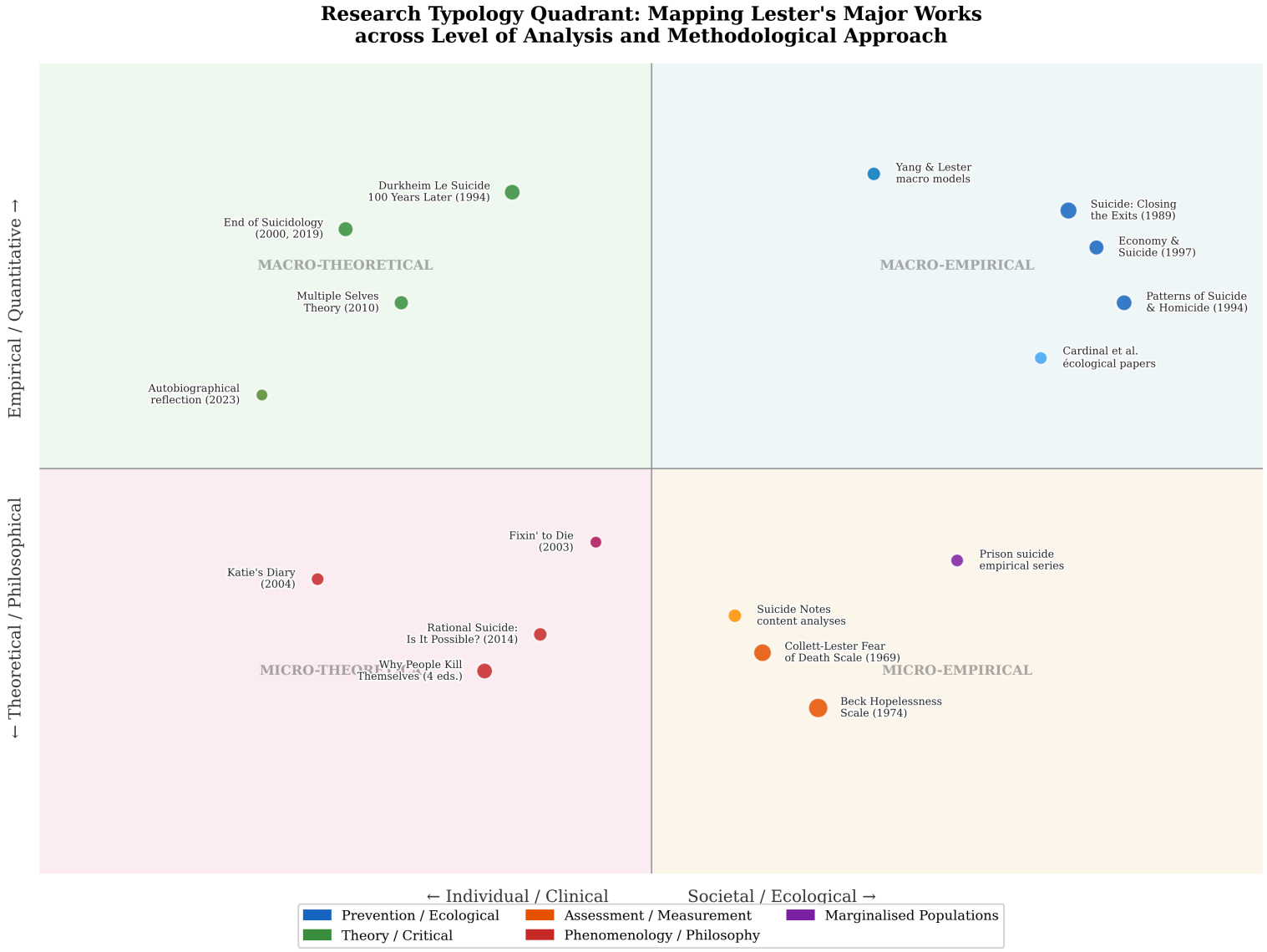

Figure 6. Research typology quadrant mapping major works by level of analysis (individual/clinical to societal/ecological) and methodological approach (theoretical/philosophical to empirical/quantitative). Bubble size approximates citation impact. The quadrant illustrates Lester's systematic coverage of all four methodological zones — a signature of his pluralist approach.

Thematic Synthesis: Thirteen Intellectual Contributions

Framework I: Prevention Science

Framework I encompasses Lester's contributions to understanding and reducing suicide at the population level. The four themes within this framework — means restriction, cross-national ecology, the economics of suicide, and homicide and violence — share a common methodological signature: they work at the macro level, use aggregate data, and are oriented toward understanding the conditions that produce elevated or reduced population rates of suicidal and violent behavior.

Theme 1: Means Restriction as the Foundation of Prevention Policy

Lester's most consequential contribution to applied suicidology is the means restriction paradigm — the systematic empirical and theoretical demonstration that restricting access to lethal agents reduces suicide rates without proportional substitution to alternative methods. The foundational text is *Suicide: Closing the Exits*, co-authored with criminologist Ron Clarke (Clarke & Lester, 1989; reissued 2013). The title captures the core argument: suicide can be prevented not by changing the mind of every person at risk but by closing the physical pathways through which they might act.

The empirical program assembled a convergent evidence base across multiple agent types and national contexts. The detoxification of domestic gas in Britain during the 1960s and 1970s — replacing lethal coal gas with natural gas — was associated with a sustained reduction in overall suicide rates, not merely a method-shift to other means. Parallel findings emerged for coal gas in other countries, domestic firearms availability and storage practices in the United States, analgesic packaging regulations in the United Kingdom (Evans et al., 2012 built directly on this work), bridge barriers in Switzerland and Hong Kong, and motor vehicle exhaust controls. *Preventing Suicide: Closing the Exits Revisited* (Lester, 2009) updated this evidence base two decades later; *Firearms and Suicide Prevention* (Lester, 2019) extended it with focused attention to contemporary gun-access policy. The policy implications have been substantial: World Health Organization guidelines on suicide prevention, national safe-storage legislation, and bridge barrier programs in multiple countries all draw on the intellectual foundation Lester and Clarke assembled.

The theoretical grounding drew on Clarke's situational crime prevention framework: behavior occurs at the intersection of motivated individuals and situational opportunity; reducing opportunity reduces incidents even without reducing motivation. Applied to suicide, this represented a genuine paradigm shift — moving prevention from the purely clinical (change the person) to the environmental (change the situation). It resolved an important empirical puzzle: why do clinical interventions, despite their scientific basis, show modest population-level effects? The means restriction answer is that they address motivation without addressing opportunity, and for many individuals at acute risk the opportunity window is narrow and time-limited.

Theme 2: Cross-National and Ecological Research

Before the era of international health databases and online repositories, Lester was manually assembling cross-national datasets — compiling economic indicators, social integration measures, cultural variables, religiosity indices, and demographic statistics from dozens of national sources — to test sociological hypotheses about suicide at the population level. *Patterns of Suicide and Homicide in America* (Lester, 1994) and *Patterns of Suicide and Homicide in the World* (Lester, 1996) were among the most comprehensive comparative treatments of their era.

The intellectual framework was explicitly Durkheimian, but Lester was not a mere expositor: he tested, extended, and challenged propositions derived from *Le Suicide* (Durkheim, 1897) across an expanding array of national contexts, time periods, and operationalizations. His use of multiple operationalizations of the same theoretical construct — social integration measured by divorce rates, church attendance, immigrant population proportions, and household density across different papers — represents a principled strategy for triangulating construct validity in the absence of measurement standardization across national datasets. Several durable findings emerged: social integration measures replicate relatively robustly across national contexts; economic inequality predicts suicide rates independently of absolute poverty; and cultural factors — particularly individualism, fatalism, and religion — moderate the strength of sociological predictors in ways that pure structural models do not capture.

Lester's 2024-2025 papers in *Suicide Studies* on methodological problems in ecological research constitute a decades-delayed self-critique of an approach he pioneered — examining confounding variables, questioning standard operationalizations, and asking whether canonical ecological analyses can support the causal interpretations routinely placed upon them. This late-career methodological critique is itself one of the most important contributions this theme produced: it is rare for a scholar who spent 40 years advancing an approach to turn around and publicly examine its limits.

Theme 3: The Economics of Suicide

Lester's marriage to economist Bijou Yang produced one of the most scientifically distinctive collaborative programs in suicidology's history. 'I learned from my wife (an economist) about some economic concepts,' he writes, listing natural unemployment rate, random walk models, and behavioral economics as frameworks he adapted for suicidology (Lester, 2023). The collaboration produced more than 200 co-authored publications across three decades — a sustained program that would be distinguished even without Lester's parallel work in other areas.

The Economy and Suicide (Yang & Lester, 1997) synthesized the macroeconomic literature: unemployment, income inequality, economic cycles, and GDP growth all predict suicide rates in theoretically interpretable ways, though the magnitude and direction of effects depends on national and historical context. *Suicide and Homicide in the 20th Century* (Yang & Lester, 1998) extended the analysis to examine whether self- and other-directed violence track common economic predictors, or whether the classic 'displacement' hypothesis — that homicide and suicide trade off against each other across different social structures — is supported by comparative data. Later work applied formal economic models directly: Yang et al. (2015) examined whether the suicide rate follows a random walk (with implications for forecastability and the detection of structural breaks); Yang and Lester (2009) explored the concept of a natural suicide rate analogous

to the natural unemployment rate; and multiple papers estimated the economic costs of suicide for comparative policy analysis. *How Culture Shapes Suicidal Behavior* (Lester, 2019) represented a late-career attempt to integrate the economic and cross-cultural streams.

Theme 4: Homicide, Violence, and the Joint Study of Self- and Other-Directed Aggression

A substantial portion of Lester's corpus — particularly concentrated in the 1980s and 1990s — treats suicide and homicide as conceptually related phenomena to be studied in parallel rather than in isolation. This reflects a theoretical commitment, visible from his earliest work, to the view that suicidal and homicidal behavior share common preconditions (social disorganization, blocked goals, low impulse control, economic strain, gun availability) that a field focused exclusively on one form of lethal behavior will systematically miss.

Suicide and Homicide (Lester, 1986) was an early synthesis. The subsequent American and World patterns books examined joint distributions across states and nations. The collaboration with Yang extended this into the macroeconomic domain. Crucially, this line of research informed means restriction analysis: if firearms availability predicts both homicide and suicide rates, then means restriction policy has a dual public health rationale that strengthens the policy case considerably. The homicide/violence theme also connects Lester's work to criminological prevention traditions — Clarke's situational crime prevention framework, Gottfredson and Hirschi's general theory of crime — enriching suicidology through cross-disciplinary synthesis that the field might not have achieved independently.

Framework II: Assessment and Phenomenology

Framework II encompasses Lester's contributions to understanding suicide at the individual and small-group level: what suicidal individuals experience, how that experience can be measured, how it is expressed in personal documents, and how the sociology of suicide relates to the experience of living in particular social contexts. The four themes in this framework — assessment instruments, suicide notes and phenomenology, the Durkheimian sociological tradition, and culture and anthropology — represent different methodological entry points into the core question: what is it like to be suicidal, and how does social context shape that experience?

Theme 5: Assessment Instruments and the Psychometrics of Death Attitudes

One of Lester's most enduring concrete contributions is the Collett-Lester Fear of Death Scale (Collett & Lester, 1969; revised multiple times through the 1990s), which disaggregated the construct of death anxiety into four distinct dimensions: fear of one's own death, fear of one's own dying, fear of the death of others, and fear of the dying of others. This multidimensional framework — developed during Lester's graduate training, motivated partly by his 1967 *Psychological Bulletin* review that established fear of death as a legitimate research construct — challenged the prevailing assumption that death anxiety is a unitary construct and generated decades of subsequent research on the differential correlates of each dimension. The four-factor structure has been replicated across multiple cultural contexts through the international validation program with Dadfar in Iran, Abdel-Khalek in Kuwait, and research teams across China, Turkey, and Eastern Europe.

Lester's second major assessment contribution is as co-author of the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974). This 20-item scale measuring negative future expectations has over 9,000 citations and is among the most widely used instruments in clinical psychology globally. It is routinely administered in suicide risk assessment, clinical trials for depression, and treatment outcome research. Its predictive validity for suicidal behavior specifically has been demonstrated across dozens of independent samples. That it bears Beck's name means Lester's contribution to it is frequently underestimated in accounts of his suicidological output; it nonetheless represents the single highest-impact measurement contribution of his career, and arguably the most important individual contribution to applied suicide risk assessment by any suicidologist. Beyond these two landmark instruments, Lester contributed to the validation and cultural adaptation of numerous other measures through collaborative psychometric programs — producing cumulative measurement infrastructure that gave suicidology richer tools than it would otherwise have had.

Theme 6: Suicide Notes, Personal Documents, and the Phenomenology of Suicidal Experience

Running through Lester's quantitative, epidemiological corpus is a consistent interest in what suicide feels like from the inside. This phenomenological thread found its most sustained expression in his analyses of personal documents, from suicide notes to diaries to published memoirs. His methodological premise — that personal documents constitute primary data about mental states at extremity — positioned him within a tradition of psychological research (Allport, Murray, McAdams) that mainstream suicidology has been reluctant to fully embrace.

The suicide note analyses applied content-analytic approaches — examining cognitive patterns (absolutist thinking, cognitive constriction, a narrowed phenomenological field), interpersonal themes (thwarted belonging and perceived burdensomeness anticipated what would later become Joiner's Interpersonal Theory of Suicide), and emotional content (guilt, shame, love, rage, ambivalence) — generating hypotheses about the psychological state of imminent suicidal crisis that clinical researchers could then test with prospective designs. *Katie's Diary: Unlocking the Mystery of a Suicide* (Lester, 2004) pursued this methodology at book length. *Perspectives on a Young Woman's Suicide* (Gunn & Lester, 2022) revisited it in a collaborative format. The phenomenological interest also expressed itself in Lester's ongoing project of writing psychological essays on approximately 120 individuals who died by suicide — from Sylvia Plath to Ernest Hemingway — posted on his website and themselves attracting secondary analysis (Zhang, Tan, & Lester, 2013). This theme represents the humanist within the scientist: a sustained recognition that suicide is not only an epidemiological datum but a human experience requiring understanding on its own terms.

Theme 7: Durkheim's Legacy and the Sociological Tradition

Emile Durkheim: Le Suicide One Hundred Years Later (Lester, Ed., 1994) marked the centennial of the most influential single text in suicidology's history with a systematic stocktaking of what the sociological tradition had established and where it needed revision. The volume positioned Lester as a steward of that tradition at a moment when biological and psychological approaches were claiming increasing dominance in the field's self-understanding.

The sociological program produced nuanced findings: social integration operationalizations replicate more robustly than moral regulation operationalizations; Durkheim's

typological classification (egoistic, altruistic, anomic, fatalistic) requires modification for non-Western and non-Christian contexts; and the relationship between modernity and suicide is more complex and historically contingent than the original formulation allowed. The broader theoretical contribution was to establish that sociological explanations — explanations pitched at the level of social structures rather than individual psychology — remain necessary components of any comprehensive account of suicide variation, and that the field would impoverish itself by abandoning them for purely psychological or neurobiological frameworks. This argument has acquired increased urgency as suicidology has moved toward individualized risk-prediction models that may systematically miss structural causes.

Theme 8: Culture, Anthropology, and the Cross-Cultural Variation in Suicidal Expression

Distinct from the ecological program — which used national data to test sociological hypotheses — Lester's cultural and anthropological work engaged with the qualitative, ethnographic, and historical dimensions of how different societies conceptualize, experience, and respond to suicide. *Suicide and Culture* (Colucci & Lester, Eds., 2013) brought together anthropologists, cross-cultural psychologists, and suicidologists to examine suicide across radically different social contexts: indigenous Australian communities, medieval Japan (seppuku), contemporary South Korea, traditional Islamic contexts, and indigenous North American communities.

This work engaged with the concept of culture-bound suicidal syndromes — the observation that suicidal behavior in some cultural contexts takes forms or occurs under circumstances that are not well captured by standard Western clinical frameworks — and with the methodological challenges of cross-cultural suicide research, including translation of concepts, measurement equivalence across cultural groups, and the dangers of imposing Western models on non-Western data. *How Culture Shapes Suicidal Behavior* (Lester, 2019) synthesized this literature comprehensively. The cultural program connects Lester's work to medical anthropology and cultural psychiatry in ways that standard suicidological research typically does not, enriching the field's conceptual vocabulary for thinking about variability in suicidal behavior across human social contexts.

Framework III: The Scholar as Architect

Framework III encompasses Lester's contributions that function less as direct empirical research programs and more as acts of field-building, structural provision, and critical reflection. The five themes in this framework — marginalized populations, personality theory, religion and ethics, pedagogy and knowledge infrastructure, and critical self-reflection — represent the ways in which Lester's project exceeded the boundaries of any individual research program and contributed to the conditions under which suicidology could function as a field.

Theme 9: Marginalized Populations — Prison, Race, and the Underserved

One of the most socially significant dimensions of Lester's corpus is its sustained attention to populations that mainstream suicidology had historically underserved. *Suicide Behind Bars* (Lester & Danto, 1993) and *Suicide and Self-Harm in Prisons and Jails* (Tartaro & Lester, 2009) were among the earliest systematic book-length treatments of suicide in correctional settings — a population with suicide rates many times the general population rate that had received limited

research attention despite the scale of the public health problem it represented. The research established epidemiological baselines, identified risk factors distinctive to the incarcerated context (arrest and booking as acute risk periods, solitary confinement effects, pre-trial detention vulnerability), and advocated for the systematic application of evidence-based prevention to correctional systems.

Suicide in American Indians (Lester, 1997) and *Suicide in African Americans* (Lester, 1998) addressed populations with distinct epidemiological profiles requiring structural and cultural analysis rather than mere application of existing models developed primarily in white, middle-class, European samples. The American Indian literature revealed the extraordinary age distribution of suicide risk in that population — an early peak with a paradoxically lower rate in older age groups compared to the general population — and pointed toward structural determinants (poverty, forced cultural disruption, land dispossession) that clinical risk-factor frameworks were poorly equipped to capture. Later extensions — *Suicide and the Holocaust* (Lester, 2005), suicide among athletes (Gunn & Lester, 2013), elderly nursing home residents, victims of intimate partner violence — continued this pattern of expanding suicidology's demographic and contextual scope beyond its comfortable center.

Theme 10: Personality Theory, Multiple Selves, and the Philosophy of Identity

The most philosophically unexpected thread in Lester's corpus is his sustained engagement with personality theory and the nature of selfhood. This program is distinctive not only for its philosophical ambition but for its originality: it represents an intellectual development that appears to have followed genuinely from Lester's reading of philosophy of mind and personality theory rather than from any existing suicidological tradition.

Running from *Theories of Personality* (Lester, 1995; updated 2019) through *A Multiple Self Theory of Personality* (Lester, 2010), *On Multiple Selves* (2015), and the founding of the journal *Studies on the Multiple Self*, this program proposes that the self is not a unified entity but a system of semi-autonomous subsystems in dialogue, conflict, and negotiation. Applied to suicide, the framework offers a distinctive phenomenological account: suicide may represent one subself's decision over the sustained or momentary objection of other subselves; the decisional process may involve a conflict among subsystems with incompatible survival orientations rather than a unitary act of will; and post-crisis accounts from survivors of serious attempts often describe exactly this structure — a self that wanted to die, a self that did not, and a self that stopped the act. This is phenomenologically distinguishable from standard hopelessness models and opens research questions that have not yet been systematically pursued. The theory has not achieved mainstream traction in suicidology, and Lester has not pressed it with the same systematic empirical machinery as his ecological programs. But it represents his most original theoretical contribution, and it positions suicidology within a broader philosophical psychology tradition that the field has been slow to engage.

Theme 11: Religion, Rationality, Ethics, and the Normative Dimensions of Suicide

Lester consistently occupied territory that most empirical suicidologists avoid: the normative and ethical dimensions of suicide. This engagement was not peripheral to his scientific work but continuous with it — reflecting a view that suicidology cannot adequately understand its subject matter while refusing to engage with the evaluative questions that surround it.

Rational Suicide: Is It Possible? (Lester, 2014) examined whether suicide can ever be a rational, autonomous act — a question with direct implications for euthanasia policy, assisted dying legislation, and the legal and clinical frameworks governing advance directives. The analysis engaged seriously with philosophical literature on rationality, autonomy, and mental competence, reaching nuanced conclusions rather than simply deploying clinical criteria to rule out rationality by definition. *Is There Life After Death?* (Lester, 2005) took afterlife beliefs seriously as a psychological and empirical question, examining near-death experience research, cross-cultural documentation of death-related beliefs, and the psychological functions of afterlife conviction. His empirical work on religion and suicide — examining whether religious participation functions as a protective factor across national contexts — produced contextually nuanced findings: religious participation protects in some national contexts but not others, organized religiosity and private religiosity exert somewhat different effects, and the direction of causation between crisis, religious disengagement, and suicidal ideation is difficult to establish from ecological data alone.

Fixin' to Die: A Compassionate Guide to Committing Suicide or Staying Alive (Lester, 2003) remains the most controversial item in his bibliography: a book that takes seriously the perspective of someone who has decided to die and provides practical information on both suicide and alternatives. It attracted hostility from within the field. It is also consistent with a general stance — visible throughout Lester's corpus — that suicidology should engage with the full human reality of suicide rather than treating all suicidal acts as pathological failures requiring external correction, regardless of context, rationality, or expressed preference.

Theme 12: Pedagogy, Textbooks, and Knowledge Infrastructure

It is easy to overlook Lester's pedagogical contributions when reading his bibliometric profile — they do not produce high citation counts, they are rarely referenced as intellectual contributions in review articles, and they do not generate the theoretical controversy that can sustain a research program's visibility over decades. But the pedagogical dimension of his work may ultimately be the most structurally important contribution he made.

Why People Kill Themselves, across four editions spanning 28 years (1972, 1983, 1992, 2000), constituted a living literature review — the most comprehensive systematic synthesis of suicide research available to practitioners and researchers in each edition's decade. In the pre-database era, when even well-resourced researchers could not efficiently access the distributed literature, Lester's reviews were a primary tool for understanding the field's state of knowledge. *Correctional Counseling and Rehabilitation*, co-authored with Van Voorhis and Braswell across seven editions (1987-2009), trained generations of correctional psychology practitioners. The Durkheim centennial volume, *Suicide and Culture*, and numerous other edited collections assembled the field's knowledge at moments when it needed integrating. The Collett-Lester scale and his contribution to the Beck Hopelessness Scale provided measurement tools that hundreds of independent researchers worldwide have deployed, validated, and built upon. And *Suicide Studies* itself — the journal he founded — provided a publishing outlet specifically designed for work that does not fit the standard journal mold: theoretical essays, brief empirical reports, methodological commentary, and critical analyses that major journals routinely decline. The infrastructural dimension of Lester's work created the conditions under which others could do suicidological research more effectively, and this contribution deserves explicit recognition alongside his individual empirical findings.

Theme 13: Critical Self-Reflection and the End of Suicidology

Perhaps the most intellectually honest contribution Lester made to suicidology is the one that most directly challenges his own project: the sustained argument that the field has not made adequate progress in understanding or preventing suicide despite decades of accumulating evidence.

The End of Suicidology thesis appeared first as a brief commentary in *Crisis* (Lester, 2000) and was expanded to book length in *The End of Suicidology* (Lester, 2019). Its central claim is that suicidology has accumulated findings without achieving the theoretical integration that prevention requires — that the field knows many things about suicide without knowing, in any mechanistic sense, why people die by suicide or how to prevent it reliably. This is not a counsel of despair: it is a diagnosis of a structural problem (accumulation without integration) that has a potential resolution (programmatic theoretical development with dedicated empirical testing). Lester continued publishing for decades after advancing this argument, which is not a contradiction but a consistent position: accumulation without integration is the problem, not accumulation per se.

His 2023 autobiographical essay poses the evaluative question directly: 'A commonly asked question is whether the scholarly contributions are any good. Are they useful? Do they advance our understanding of suicide?' His answer — 'that is not for me to worry about or to answer. It is for others to answer' (Lester, 2023) — is simultaneously intellectually modest and a provocation to the field. The most recent papers (Lester, 2024, 2025) continue methodological critique: examining confounding in ecological studies, questioning canonical analytical approaches, asking whether foundational theories can be modified in light of contradictory evidence. This sustained critical engagement from within is a scholarly act that defines what intellectual honesty looks like in a mature career.

Integrative Analysis: What the Corpus Means as a Whole

Systematic Pluralism as Scientific Philosophy

Reading Lester's corpus as a whole — not any single paper or book but the full arc of 62 years across all thirteen themes — reveals a distinctive scientific philosophy he did not often name explicitly but consistently enacted: systematic pluralism. This is the conviction that no single theory, method, or level of analysis can adequately explain suicide, and that the only intellectually honest response is to test everything available, at every level of analysis, with every accessible methodology, across every accessible sample.

This philosophy explains features of his output that otherwise seem inconsistent. The author of rigorous means-restriction research also wrote detailed psychoanalytic case analyses. The quantitative ecologist also produced close readings of individual diaries. The scientist who accumulated thousands of brief empirical findings also published a sustained critique arguing that accumulation is not enough. The behavioral epidemiologist also wrote about multiple selves and the philosophy of personal identity. These are not contradictions — they are expressions of a systematic commitment to holding the full complexity of suicide in view without premature

closure around any single framework. Lester (2023) describes reading everything written on suicide from 1897 to 1997 — a century of literature across psychology, psychiatry, medicine, religion, sociology, anthropology, feminism, and criminal justice. This breadth of reading was itself a scientific act: it prevented the tunnel vision that specialized research programs routinely produce, and it enabled the cross-disciplinary synthesis that was Lester's most distinctive methodological signature.

As Figure 6 illustrates, Lester's major works span all four quadrants of the research typology matrix — macro-empirical (ecological studies, economic models), macro-theoretical (Durkheim commentary, *End of Suicidology*), micro-empirical (assessment scales, suicide note analyses), and micro-theoretical (multiple selves theory, philosophical ethics). This coverage across the methodological space is not accidental: it reflects a principled view that each quadrant captures something real about suicide that the others cannot, and that a field dominated by any single methodological zone is necessarily incomplete.

The Infrastructure Builder

Beyond his research findings, Lester built infrastructure for the entire field. This dimension of his contribution is the most likely to be underweighted in citation-based assessments, and it may ultimately be the most consequential. As shown in Figure 4, all three research frameworks rest on a shared infrastructure layer: the journals (*Suicide Studies*, *Studies on the Multiple Self*), the textbooks and literature reviews (*Why People Kill Themselves* across four editions; *Correctional Counseling and Rehabilitation* across seven editions), the assessment scales (Collett-Lester Fear of Death Scale; Beck Hopelessness Scale), the edited reference volumes, and the international collaborative networks.

This infrastructure layer did not emerge accidentally from a productive career — it appears to have been deliberately constructed, consistent with a conception of the suicidologist's role that extended beyond producing findings to producing the conditions under which findings could be produced, evaluated, integrated, and applied. The founding of *Suicide Studies* is the clearest evidence of this: Lester created a journal not primarily to have an additional publication venue but because he identified a structural gap in the field's publication infrastructure — the absence of an outlet specifically oriented toward the breadth and diversity of suicidological work, including short empirical communications, theoretical essays, and methodological commentary.

Cross-Theme Connections and Intellectual Synergies

The thirteen themes are not independent: they form a network of intellectual connections that constitute much of the corpus's value. Several particularly important cross-theme linkages deserve explicit identification. First, means restriction and ecology are connected through the natural experiment logic: cross-national variation in suicide rates provides evidence for means restriction hypotheses, because countries that restrict access to specific methods show suppressed rates for those methods. This connection turned ecological research into applied prevention science, not just academic sociology. Second, assessment instruments and phenomenology are connected through the construct validity question: what scales measure is partly determined by what suicidal experience actually involves, and the suicide note analyses provided phenomenological anchor points for interpreting the psychological constructs that scales

operationalize. Third, critical reflection and pedagogy are connected through a shared concern with how the field knows what it knows: the *End of Suicidology* critique is partly a critique of how suicidology's textbooks and review articles represent the state of knowledge, and the commitment to writing better reviews (*Why People Kill Themselves*) is itself a response to that concern.

Significance and Legacy

What changed in suicidology because of David Lester's work? We identify six areas of demonstrable impact. First, means restriction is now established prevention policy. The empirical and theoretical program contributed directly to World Health Organization guidelines, national firearm legislation debates, bridge barrier installations on at least five continents, and analgesic packaging regulations in multiple countries. Second, cross-national ecological methodology is now a standard tool. The comparative turn Lester pioneered — testing sociological hypotheses across national datasets — is embedded in major journals and international collaborative programs that did not exist when he began. Third, the Collett-Lester Fear of Death Scale and the Beck Hopelessness Scale are among the most widely deployed instruments in thanatology and clinical psychology respectively, with validation studies in dozens of cultural contexts. Fourth, *Suicide Studies* provides a publishing outlet that fills a genuine gap for work too brief, too theoretical, too methodologically unconventional, or too critical for mainstream journals. Fifth, Lester's internationalization of collaboration brought suicidology into productive contact with scholars in Italy, Iran, Kuwait, Hungary, Australia, Malaysia, China, Turkey, and beyond, creating research relationships and local programs that continue independently of him. Sixth, and most underappreciated, his pedagogical infrastructure — the literature reviews, textbooks, and edited reference volumes — gave practitioners and researchers access to the field's cumulative knowledge during decades when that knowledge was otherwise distributed across thousands of sources with no systematic synthesis.

Critical Assessment

A fair assessment must acknowledge the corpus's limitations alongside its contributions. Three areas of legitimate critique require explicit statement.

First, the brief note publication strategy raises concerns about depth and replicability. A one- to three-page study reporting an ecological correlation in a single national sample provides insufficient space for methodological detail, sensitivity analysis, or discussion of alternative explanations. Many findings have never been replicated — not necessarily because they are wrong, but because they are too numerous and too small for any systematic replication program to prioritize. The field would benefit more from a smaller number of robust, well-powered, pre-registered replications than from continued accumulation of brief correlational reports. Lester himself has recently made this argument (Lester, 2024, 2025), which should be taken seriously.

Second, the ecological fallacy applies to a substantial proportion of the cross-national program. Associations between national-level variables cannot be straightforwardly interpreted as evidence about individual-level causal processes. Lester acknowledged this limitation repeatedly in methodological writings, but the caveats have not always been reflected in the strength of language used in brief empirical reports. Readers should apply this caution systematically when building on ecological findings.

Third, the citation profile is somewhat misleading as a measure of distinctively suicidological impact. The h-index of 96 is substantially driven by the Beck Hopelessness Scale paper, which reflects clinical psychology broadly, not suicidology specifically. The i10-index reflects the volume of brief empirical notes, which attract few individual citations. The distribution is bimodal: one extraordinarily high-impact paper, a modest number of moderately-cited works, and a long tail of minimally-cited brief reports. This is not unusual for prolific scholars publishing across multiple outlets, but it means that headline metrics somewhat overstate the depth of influence of Lester's distinctively suicidological contributions.

These critiques do not diminish the legacy — they locate it more precisely. Lester's impact is greatest where his work was most programmatic (means restriction, cross-national ecology, assessment instruments, infrastructure building) and least where it was most rapid and scattered. This distinction should inform how the field reads and builds on his corpus.

Conclusion

David Lester is, by any quantitative measure, the most prolific individual contributor in the history of suicidology. But the number 3,218 — the count of his publications — is not the most interesting thing about his work. The most interesting thing is what that work was trying to do.

It was trying to hold suicide in full view: biologically, psychologically, sociologically, economically, culturally, philosophically, and ethically. It was refusing the disciplinary and methodological shortcuts that would have made the work tidier but narrower. Across thirteen themes, three frameworks, and a foundational infrastructure layer, it built the conditions under which suicidology could function as a genuinely multidisciplinary science rather than a specialty within clinical psychiatry. And it was, ultimately, willing to say out loud that the project had not fully succeeded — that suicidology still does not know, in the mechanistic sense that prevention demands, why people die by suicide.

'Perhaps my answer may be seen as avoiding the issue,' Lester wrote of the question of whether his contributions were useful. 'Truly, that is not for me to worry about or to answer. It is for others to answer' (Lester, 2023). We accept that invitation. Our answer is: yes, substantially, in identifiable ways, with identifiable limits. Means restriction works and has become policy. Cross-national methodology is legitimate and productive. The assessment instruments are in use in laboratories and clinics on every inhabited continent. *Suicide Studies* sustains a form of scholarly communication the field would otherwise lack. The literature reviews and textbooks gave the field its memory across 30 years of pre-digital scholarship.

What remains is to build on this foundation with greater depth and power than the rapid-note strategy could achieve. To take the most productive programs — means restriction, ecological analysis, cross-cultural assessment, the economic approach — and extend them with the rigor, replication, and theoretical integration that brief empirical notes cannot provide. Lester himself pointed to this need in the *End of Suicidology* critique. Honoring his work means taking that critique seriously, not setting it aside out of deference to his productivity. He was right that more was needed. The field should prove him wrong by producing it.

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THE SUICIDES OF VIRGINIA GIUFFRE AND JEFFREY EPSTEIN

David Lester
Stockton University

Preamble

Yes. I know that many think that Jeffrey Epstein was murdered in prison. Some argue that Marilyn Monroe was murdered, and there are rumors that Vincent van Gogh was accidentally shot by two adolescents. It is toss up whether it is more likely that murders are covered up or that suicides are covered up by law enforcement and the relatives of the person. Suicide is common in prisons (Tartaro & Lester, 2009), even on death row (Lester & Tartaro, 2002). This essay, however, takes the stance that both deaths of the protagonists were suicides, and searches for clues as to why they died by suicide. For those who want information on whether Epstein's death was suicide or murder, the Wikipedia article on him has relevant information.

But: at the time of writing this essay, an article appeared in the *New York Times Magazine* (Homans, et al., 2026) that had detailed information about the circumstances confronting Epstein in the prison, including information from an inmate in the neighboring cell when Epstein died, that convinced the writers of the article (and me) that Epstein's death was a suicide.

VIRGINIA GIUFFRE

Note: The offenses documented in this section are reported in Virginia Giuffre's autobiography. The offenders may have denied the offenses, but I believe Virginia's account. Recent events and the Epstein files support her account.

Virginia's time-line:

Born: August 5th, 1983, in the USA
Ran away from juvenile detention in Palm Beach County in 1998
Raped
Picked up serendipitously by a sex trafficker, Ron Eppinger

Sexually abused by Epstein and his associated from the ages of 17 to 19
Escaped from Epstein in 2002
Married: Robert Giuffre, October 16, 2002, ten days after they met; had three children; separated, 2024
Died by suicide: April 25th, 2025, in Australia

Virginia's Early Years

Virginia was born in Sacramento, California, to Lynn Cabell and Sky William Roberts. She had a half-brother, Daniel Wilson, from her mother's previous marriage and a brother Sky Rocket Roberts five years younger than she was. The family moved to Florida in to be close to her maternal grandmother, and Virginia described her early years there as good. The family had many animals, pets, the neighborhood was friendly, and there was a lot to do in their pond and in the woods. When she was six, she came home to find that her father had bought her a horse, and she loved riding and exploring with her horse, Alice. She decided that she wanted to be a vet.

But at that time, things changed. Virginia's mother made her do more chores, taking care of the animals they owned and doing household tasks. She also made Virginia act more feminine, wearing dresses to school and stopping her tomboy ways.

At age seven, more sinister acts occurred. Her younger brother started sleeping in the parents' bedroom. Then her mother stopped getting Virginia ready for bed, and her father took over. Soon, her father was sexually abusing her. Her mother grew cold towards her and started physically abusing her – whipping her with thorny rose branches. It appears that the parents choose this path, the father to treat Virginia as his sexual outlet, while the mother expressed her anger about this toward Virginia rather than her husband. Virginia's father has denied that he sexually abused Virginia, but that is to be expected. To admit it would force him to feel shame. Virginia got urinary tract infections at this time, lost bladder control, was called *Pee Girl* at school and was punished by her mother.

The next step was that a friend of her father, Forrest, and her father swapped and abused each other's daughters and, eventually they jointly raped Virginia. In 1990, Forrest's daughter filed a complaint against her father, got a restraining order against him, and moved to live with a relative. Later, in 2000, Forrest was convicted of sexually abusing another girl and was a registered sex offender from 2001 to 2011.

Virginia switched from being a hardworking student to being angry, defiant and prone to emotional breakdowns, as well as drinking and partying. She cut class, starved herself, smoked marihuana and got into fights with others. One good event was made possible by a neighbor who used horses (often abused horses) to help disabled children. Virginia used to visit often and help out with the horses and the children. At home, Virginia' mother was habitually drunk and physically violent toward her, in addition to her father's abuse.

. She entered middle school at the age of thirteen. Virginia had anger toward both parents. She ran away from home often, associated with the "bad" kids at school and searched for fights. When she was fifteen, her mother tricked Virginia into entering a juvenile detention center (*Growing Together*). *Growing Together* was eventually exposed for using beatings, imprisonment and humiliation, and it was closed. It was from here that Virginia ran away in 1998 when she was fifteen.

Eppinger and Epstein

Almost immediately after Virginia ran away from the juvenile detention center, she was sitting by the road when Ron Eppinger, driving by, picked her up. He groomed Virginia as a $1,000 a night escort (prostitute) in addition to raping and brutalizing her himself. This is the first time in her memoire that she had mentions having thoughts of suicide. She and the other girls took Xanax and oxycodone to numb the pain. She describes herself as a defeated, hopeless child, just trying to survive. She was still just fifteen.

After six months, Eppinger gave Virginia away to a man in his 50s. The police broke into his house and arrested him, took Virginia to the police station and called her father. He had her taken back to *Growing Togeth*er from which she ran away again. She roamed around and finally moved in with a boy, Michael, who proposed marriage. They lived in a travel trailer in her parents' yard and had part-time jobs.

Then her father got a job at Donald Trump's Mar-a-Largo Club, and got Virginia a job there as a locker room attendant for $9 an hour. After a few days, her father introduced Virginia to Donald Trump who paid her extra to babysit the children for his friends. She was turning seventeen, and life was okay finally, and then….

Ghislaine Maxwell was driving by and saw her, persuaded her to go for an interview to learn how to become a masseuse that night after work. Her father drove her over and, inside the house, Virginia met Jeffrey Epstein. Maxwell taught her how to massage using Epstein as the subject, and it soon turned into group sex. Virginia spent more than two years, she says, with Epstein and Maxwell, the details about which have now been in the news for many years.

Virginia was with Epstein and Maxwell from the ages roughly of 17-19. It began with giving massages and sex with Epstein and Maxwell, and proceeded to being sent to have sex with other men, including one sadist who inflicted great pain on Virginia. At the same time, Virginia shared an apartment, paid for with Epstein's money at first with her boy-friend Michael, and then with Tony a boy-friend from younger days in middle school. During the times when Epstein was gone from Florida, Virginia found odd jobs, with a veterinarian and in restaurants.

Parts of her life with Epstein were extremely unpleasant, but Virginia flew to all of Epstein's luxurious dwellings and **s**tayed in hotels in fine hotels in Europe and elsewhere. And she was able to keep her apartment, even though she was at Epstein and Maxwell's beck-and-call 24/7. The pay-off in the future for Epstein's girls was to get money to better their lives and jump-start their career or to marry one of his rich friends.

To cope with her life, Virginia took Xanax and ecstasy. At one point, Virginia fell ill, with heavy bleeding, and had a minor surgery in hospital. She later found out that she had suffered an ectopic pregnancy.

Two things happened which changed her life. First, Epstein read about the Marquis de Sade's sexual desires and began to use them on Virginia, binding her hands and feet and tying her to a chair with a metal-studded collar around her neck. Then, in the summer of 2002, Epstein and Maxwell told Virginia that they wanted her to have Epstein's child but give up all legal rights to the baby. She was to pretend that she and Epstein were couple and help with the child, especially during travel, but that the child would always remain with him if they broke up.

Virginia made a decision. She told them that she would have Epstein's baby under those conditions but, when she first met them, they had promised that she could get formal training as a masseuse. She wanted massage training before having Epstein's baby. Maxwell found a school in Thailand that offered an eight-week course. In September 2000, loaded with luggage and with arrangements that she would receive funds from them, Virginia flew to Thailand.

Thailand

Supported by funds from Epstein, Virginia began her massage course and enjoyed it, except for daily telephone calls from Maxwell. She still had mild symptoms of PTSD and took Xanax and other drugs. She met a fellow student, Matt, from Australia, with whom she went to a Thai gym where his friend Robbie, aged 26, would be. While watching the boxing, Virginia and Robert met and immediately fell in love. Virginia was honest with him about her past. In a few days, Robert asked her to come to Australia with him. On October 16, 2020, just ten days after meeting, they were unofficially married in a Thai ceremony (and officially married later in Australia) and decided to go to Australia.

Virginia called Epstein to tell him that she had fallen in love and got married. Epstein said, "Have a great life" and hung up.

Australia

In Australia, her mother and father-in-law soon got to like Virginia, and Virginia and Robert had a good marriage with, of course, arguments and difficulties but, according to Virginia's account, no worse than any marriage, despite the first few years being "tough" on both of them. Of course, Virginia had to learn a lot. For example, she had never opened a bank account or loaded a dish washer. Robert, knowledgeable about her past and the abuse, was very supportive, especially during her panic attacks.

They had three children: Alex in February 2006, Tyler in April 2007, and in January 2010 a daughter Ellie. From Virginia's account, Tyler seems to have serious disabilities as a baby and toddler (it sounds like autism) but, with training, he seems to have become more normal as he grew up. He changed from a frustrated nonverbal child to a thriving chatterbox.

Problems

Several problems occurred. Virginia wanted to have a better relationship with her father, who had raped her as an adolescent, a foolish desire given the type of defective man he had been and still was. Twice she had him visit Australia, and

both visits turned out badly. During the second visit, they threw him out and got him an earlier flight back to America.

Robbie was in car crash and injured his spine, making work and helping out with children difficult. But Virginia found a good psychotherapist who helped her come to terms a little with her trauma and, later, in September 2011, she found another excellent psychotherapist who diagnosed and treated Virginia's PTSD

At this time also, the legal problems began to impact Epstein. In 2007, Epstein and Maxwell called Virginia out of the blue and urged her not to cooperate with the investigations and, if she did not cooperate, they would take care of her. This began a series of events, many of which Virginia found unpleasant but thought necessary to avenge all of the girls that Epstein and Maxwell had abused. However, her involvement meant that, as she talked about the events of her past, she would have to relive all of the abuse that she had suffered. She also was thrust into the public eye, and that not all of the response was positive. In fact, she was labeled negatively, called many derogatory names and threatened. She saw people hanging around her house and stalking her. This added to her PTSD.

Virginia was contacted by the Department of Justice and interviewed for months by the lawyers they recommended. Then she found out that Epstein had avoided a trial by pleading guilty to lesser offenses. A suited was filed for her under the name of Jane Doe in May 2009 and, in November 2009, Virginia agreed to a confidential settlement for $500,000. Epstein's victims were criticized for accepting these deals, but Virginia was angry at the criticism because it was the Department of Justice that had settled without a trial.

For the first time, Virginia and Robert could buy their first house and live comfortably.

However, Virginia's anger grew at the way in which powerful men could escape justice. Sharon Churcher, who worked for the tabloid *Daily Mail* in England, had wanted to search out Jane Doe. Virginia heard of this and described her reaction as both validating and terrifying. Virginia contacted Churcher via email on February 2011. Churched called and then visited Virginia in Australia. This was when the photo of Virginia and Prince Andrew surfaced. Virginia agreed to go on the record, and Churcher's story appeared in the Daily Mail on February 27, 2011, under the heading: *Prince Andrew and the 17-Year-Old Girl His Sex Offender Friend Flew to Britain to Meet Him*.

Virginia accepted $164,000 for use of that photo, and she was accused by some of making things up for profit. She wrote a 130-page (unpublished) book entitled *The Billionaire's Playboy Club*, in which she changed details such as names and places which then resulted in Virginia being attacked for inaccuracies.

Once the story broke, Virginia was sought out by other reporters and paparazzi too, so that Virginia and her family had to leave their house and hide. However, on March 17, 2011, the FBI interviewed Virginia for the first time. Also, Brad Edwards, who had filed a lawsuit challenging the legality of the federal government's non-prosecution settlement with Epstein, made contact with Virginia to talk about the Epstein case.

Virginia was now energized to fight Epstein, and she and Roberts decided to move to America, at least for a while. They sold their house and moved to Titusville, Florida in October 2013. Much, if not most, of the time was taken up with Virginia's cooperation with lawyers endeavoring to prosecute Epstein and Maxwell that lasted until Epstein's death and Maxwell's criminal conviction. During this time, there were many successes, but also a great deal of pain for Virginia (and Robert). She was attacked in the press and online and accused of being a prostitute and after money. There were reporters and paparazzi after her, and occasional stalkers, causing on one occasion to hide her three children in a closet while she tried to confront a parked car with its headlights on outside her house one night. They often came home to find dead-bolted doors unlocked. After she had returned to Australia, the FBI called her to warn her of credible threats on her life.

Virginia stayed in touch with her psychotherapist in Australia who helped her deal wither PTSD symptoms and anxiety attacks.

Virginia also attempted once more to build a relationship with her father, and she told her two brothers how he sexually abused her as a child (aged 7-11). Her older brother, Danny, told his daughter's school to never let her grandfather pick her up from school, and he never spoke to his father again. Virginia found out that Epstein had paid her father hush money. At that point, she finally told her father that she would never see him again, and she and Robert moved to Colorado to be near her mother and to try and mend that relationship. Her mother had remarried, and she became an adoring grandmother to Virginia's three children.

Robert's father in Australia became ill with cancer and asbestiosis, and so they decided to return home to Australia. Robert flew home in July 2015, and

Virginia and the children in October 2015. Although being back in Australia was beneficial for the family, it meant that Virginia had to fly frequently to America to participate in the proceedings again Epstein and Maxwell (for example, four times in 2016). Robert got a job in security, and they avoided becoming bankrupt. In the Spring of 2107, Virginia won her civil suit against Maxwell for slander and obtained a financial settlement (which remains secret) which eased their money troubles.

The year 2017 saw a change in America. Harvey Weinstein was shown to have sexually abused many women and the *Me Too* movement grew in strength. The tide began to turn against Epstein and Maxwell, and several of the legal proceedings were successful, especially after the articles and recorded interviews by Julie Brown of the *Miami Herald*. After Browns' first story aired in November 2018, the Southern District of New York opened a new investigation of Epstein.

The FBI warned Virginia of threats to her life, and she wrote on her Twitter page: **I am making it publicly known that in no way, shape, or form am I suicidal**.

Epstein was arrested on July 6, 2019, and on August 10 found dead by hanging in his prison cell. Maxwell was arrested on July 2, 2020.

The New York investigation opened a window for victims of sexual abuse to file claims, and Virginia and other Epstein victims took advantage of this to file suits. Virginia also filed a civil suit against Prince Andrew. Virginia was interviewed by Savannah Guthrie that aired on NBS's *Dateline* and, later an interview with her aired on *60 Minutes Australia*. Because she worried what people might say to her sons (aged 12 and 13),, she let them watch it. Alex was angry, while Tyler cried and hugged Virginia and told her that he was proud of her. Virginia admits that every re-telling her stories hit her hard, increasing her PTSD symptoms. Robert stood by her but advised her to stop because the stress was affective her health.

A number of crises occurred. Virginia came down with meningitis (perhaps after a mosquito bite). Trying to get out of bed one day, she fell and broke her neck, requiring surgery in August 2020 (an anterior cervical discectomy), and the pain led her to take prescribed oxycodone. She came down with pneumonia. All of this while, although the legal cases were proceeding successfully, Virginia was still verbally abused in the media.

More medical problems occurred: a staph infection in February 2021, laparscopic surgery, both she and Robert caught COVID, then in June 2022, fibromyalgia and later a second neck surgery. She attempted suicide with an overdose while in the hospital and later after her release back home, this time saved by her son. Her doctors gave her ketamine to help her manage her PTSD.

During this time, Virginia still fought. She gave testimony in France against one of her abusers, Jean-Luc Brunel, who died by suicide on February 19, 2022. On August 9, 2021, she sued Prince Andrew who latter settled out-of-court, paying both Virginia and her non-profit charity (Speak Out, Act, Reclaim – SOAR). Maxwell's trial started on November 29, 2021 and Maxwell was convicted and sentenced to prison on June 28, 2022. Both Robert and Virginia were delighted at the verdict.

Virginia tells of buying Robert a power-boat and asking Robert to lock up her pain medications. They bought a 40-acre farm near Perth on which they planned to have horses, a few sheep and bees. Virginia's book ends in 2022, three years before her death and the problems that are detailed below. There is no mention of these problems in her autobiography/

From Wikipedia and Josie Ensor

Wikipedia has important information. First, when they were in Colorado, Robert was arrested in 2015 and placed on probation for domestic violence. After Virginia's suicide, her family said that Virginia had said that Robert had been physically abusive for several years. Back in Australia, Robert was drinking heavily, gambling their money away and consumed by jealousy. They separated in late 2023 or 2024 and lived in separate houses. Virginia said that she had been unhappy in the relationship for many years and no longer loved Robert.

Virginia said that Robert had been physically violent in January, 2025, assaulting her after she declined to have sex with him. She was later photographed with bruises on her face. Robert claimed that she had attacked him. The police investigated but pressed no charges. Robert got a family violence restraining order, and Virginia was prevented from seeing her children for six months. At the time of her suicide, she was still in a custody battle over her children and in divorce proceedings.

Virginia had a car crash in March 2025 as a passenger. She was injured and eventually hospitalized. Her brothers flew to Australia to help her. She was

discharged from the hospital on April 7, 2025. According to her brother Sky, Virginia was struggling physically and emotionally

Virginia died by suicide at her home on April 25, 2025, aged 41, possibly from a drug overdose. Sky went to check on her the next morning and heard music playing and so left her alone and went out. He returned at 8 pm and, when he could not get her to respond, broke into her bedroom and found her dead. He declined to state the method for her death. Giuffre's public representative, Dini von Mueffling, said that Giuffre had "confided in me [in the weeks before her death] that she had planned to commit suicide, down to the method." Some in social media have suggested that her death was from an accidental overdose.

Discussion

From this essay, it would seem inevitable that Virginia would die by suicide, given that she had so many risk factors, starting with sexual abuse by her father which then continued with Jeffrey Epstein. Research has been documenting the link between childhood sexual abuse and suicide from 1986 until today.

Virginia had PTSD according to her second psychotherapist which explains her anxiety attacks. Her involvement in the legal cases against Epstein and Maxwell created additional trauma as she relived the abuse while documenting it. Going public also resulted in verbal abuse from the public who doubted her accounts. The information available since then, including the documents released as part of the Epstein files from the Department of Justice, validates all that Virginia and other victims reported.

Virginia also had extreme medical issues, from pneumonia to meningitis to neck surgery. She was in pain and taking pain medication at the time of her death. The disruption of her marriage and, if true, the claims about Robert's behavior, all indicate additional stress, in particular the ending of support from Robert who had provided support in the early years of their marriage. Her two attempts at suicide after getting COVID are also risk factors for later suicide.

There are other issues that are of interest, although not critical for understanding Virginia's suicide. Her quest to build a relationship with her father, who was a self-centered predator, created stress for Virginia, but such quests are not unusual in women who were abused by their fathers. Indeed, some do manage to build a relationship and, to some extent, overcome their hatred. Virginia was more successful to build a relationship with her mother.

Virginia's desire to bring Epstein and Maxwell to justice is understandable, but doing so was probably the cause of the deterioration of her marriage to Robert. He most likely felt abandoned by her, taking second place to the fight for justice. If the reports of his behavior in the months before Virginia's suicide are true, their marital disintegration almost certainly added to the Virginia's stress. The presence of her brothers in the last few weeks was helpful, but obviously not enough.

Because of Dini von Mueffling's report of Virginia's conversation with him (assuming we believe it), Virginia's death is almost certainly a suicide and not an accidental overdose, and her suicide is understandable given the many risk factors documented in this essay.

JEFFREY EPSTEIN

At first glance, Epstein's suicide is obvious to me. I have written many articles on the role that shame plays in suicide (Kalafat & Lester, 2000; Lester, 1998a, 1998b; Lester & Baker, 1989; Stack, Bowman & Lester, 2024).

In the 1980, the US Postal Service and the US Customs Service initiated programs to catch and prosecute those who purchase child pornography through the mail. Of the first 162 men arrested, four died by suicide (Lester & Baker, 1989). After a police Royal Commission in Australia on police corruption in 1997, at least ten of those investigated died by suicide, including a Supreme Court Justice accused of homosexual pedophilia (Lester, 1998b).

Lester (1997) documented several similar examples. Captain Ernie Blanchard, the U.S. Coast Guard's chief of public affairs and top spokesperson, told several sexist jokes when addressing the cadets at the Coast Guard Academy in New London, Connecticut, on January 10, 1995. Academy officials and cadets complained, and Blanchard faxed a letter of apology three days later. The Coast Guard then launched a criminal probe into the affair, and some Academy instructors argued that he should be punished. The probe threatened to end Blanchard's career and his pension. He worried about the newspaper publicity and the humiliation for his children. Colleagues avoided him. He offered to resign, but his offer was rejected on March 10, 1996. Three days later, he asked his chief for time off, and his chief later said that Blanchard was mortified that he had caused such potential embarrassment to the Coast Guard and his family. The next day, Blanchard shot himself in the head in his garden at home, leaving no suicide note.

Not long after Blanchard's suicide, Admiral Mike Boorda, chief of naval operations, was warned that two correspondents from *Newsweek* were coming to question him about why he had worn combat medals among his decorations when he was not entitled to do so. In fact, he had stopped wearing them a year earlier when he learned that people were inquiring as to whether he deserved them. That day, he went home and shot himself in the chest, exactly where he wore the decorations. In a suicide note addressed to sailors in general, he expressed his concern that the controversy would damage the reputation of the Navy. Commentators felt that the investigation into the decorations would be humiliating to Boorda, a senior officer who had served in Vietnam, but not in actual combat. In both of these cases, humiliation rather than guilt appears to be present, suggesting that shame may have played a role in both suicides.

Kalafat and Lester (2000) presented the case of a wife who attempted to die by suicide motivated by shame over what her husband had done. After his death, his letters revealed that he had a long-standing affair with a woman in the community, and knowledge of the affair was widespread. She could not face the people in her community and, out of shame, attempted suicide but was saved by a chance, unexpected visit by a neighbor.

Epstein had socialized with scores of famous and influential people, and now it was known that he was a pedophile and had trafficked adolescent girls to his friends and associates. He knew that his former reputation had been destroyed and his new reputation would arouse disgust in everyone hearing of his activities.

Not only that but, if were to be convicted and sentenced to prison, an extremely likely scenario, he would be subjected to physical violence and rape by his fellow inmates. Pedophiles are occasionally murdered in prison. The solution, keeping him in isolation, would create a psychologically painful experience.

In these circumstances, suicide is not unlikely.

But let us also examine Epstein’s life to see if there were signs of later suicidal behavior, perhaps not as extreme as those in Virginia’s life but, nevertheless, present in his life.

Filthy Rich (Patterson, et al., 2016)

Early Years

Jeffrey Epstein was born on January 20, 1953, in Crown Heights, Brooklyn to a Jewish mother, Paula Stolofsky, who arrived in America with other Lithuanian refugees. He had a brother two years younger than him. His parents were described as quiet and humble. His father Seymour Epstein, whose family emigrated from Russia, had served in World War Two and worked for the New York City of Parks as a groundskeeper and gardener. Seymour's father owned a house-wrecking company. Two friends, one of whom moved in with Epstein's parents when his own parents divorced, remember Epstein as talented. He was a good pianist and a math whiz, and had a prized stamp collection. Jews were a minority in Epstein's school and neighborhood, and there was animosity from the Italian Americans towards the Jewish residents. Epstein was described as "sweet and generous" although "quiet and nerdy", and nicknamed "Eppy", according to Wikipedia. To illustrate his generosity, later he once paid for an organ transplant for the wife of a porter in a building he owned.

Epstein took advanced math courses at Cooper Union in the East Village, Manhattan and earned money tutoring other students there. In 1971, he transferred to New York University, but he never graduated. In 1973, he began teaching math and physics at the Dalton School, a prestigious private school on the Upper East Side with rich and elite students.

In 1976, perhaps as a resulting of dating Lynne Greenberg, he met her father Ace Greenberg who was a partner at Bear Stearns, a global investment bank. Epstein started there as an assistant to a trader on the American Stock Exchange and moved up to become a junior partner. Greenberg and Epstein liked each other and worked well together. He was soon earning $200,000 a year compared to $20,000 at the Dalton School.

Epstein was then 23years old, and there is no sign of any risk factors for suicide. He is talented and clearly has a motivation to succeed in the path that he has chosen.

The Next Steps

There was little government oversight on Wall Street. Epstein worked on complex tax-related problems for wealthy clients, including the CEO of Bear Stearns, Edgar Bronfman. When Bronfman was investigated for insider trading, the SEC investigated and interrogated Bear Stearns' employees, including Epstein, but he had already resigned because of investigations into his own behavior (insider trading and making loans to friends).

In 1982, Epstein met a beautiful and wealthy actress, Ana Obregón, whose father had lost a lot of money in the collapse of an investment company. She asked Epstein for help, and Epstein worked with a U.S. attorney in New York and, after three years, recovered Obregón's money and that of others. Epstein probably earned millions from this.

During this time, Epstein dated many beautiful and wealthy women, such as Eva Andersson, *Miss Sweden*, some of whom wanted to marry Epstein, and perhaps he was tempted too. But he stayed single, and the women stayed as friends.

Up to this point, everyone liked Epstein and said nothing bad about him. The question is, how did he become so wealthy? Epstein was creative in helping the wealthy to avoid paying high taxes, most likely for a lump sum, usually in the millions or tens of millions. Epstein was involved in several possibly illegal financial affairs, but managed to avoid legal trouble. He also set up a successful business to help recover stolen money from fraudulent brokers and lawyers and told friends that he helped the government recover embezzled money. He also helped arms dealers open offshore tax havens and disguise their accounting. Epstein also worked at Towers Financial Corporation and engaged in fraudulent activities from which he made good money.

Through friends, Epstein met Leslie Wexner, the founder of *Bath & Body Wo*rks and other companies, a billionaire, who was looking for someone to untangle his finances and manage his money. Wexner and Epstein got along well and became inseparable. Epstein, who had fallen on hard times, became financially secure.

At this time, 1991, Epstein met Ghislaine Maxwell, a wealthy heiress who was the daughter of Robert Maxwell who in 1991 was under investigation or fraud and died from suicide off his yacht near the Canary Islands in the Atlantic Ocean. Ghislaine probably started as Epstein's lover but become his friend and manager.

Epstein was never a drinker, never smoked or took drugs. He took good care of his body. Patterson, et al. interviewed Dr. Anna Salter, a clinical psychologist, who said that she could not diagnose Epstein, never having interviewed him, but that narcissistic personality disorder and psychopath were the diagnoses that she would look for.

Vicki Ward, an English woman who wrote for *Vanity Fair*, interviewed Epstein in 2002 and described him as charming with steely and calculating eyes. Patterson, et al. describe Epstein as charming, one minute but the next minute he would snarl, threat and bluster.

In short, so far, I have uncovered nothing that would suggest that Epstein would die by suicide under stress. But perhaps Patterson, et al. have missed something. Let me check.

The Spider by Barry Levine (2020)

Epstein's early years were not as positive as Patterson, et al. imply. The area in which he was born was in decline and the school Epstein attended was considered rough. Later, Epstein admitted feeling disgust at the circumstances of his upbringing and angry at the lower-middle-class label attached to him. He felt trapped in a life of poverty. But classmates described him as having carefree charisma and occasional arrogance.

His behavior as a teacher at the Dalton School was odd. He did not dress like a teacher (he wore gold chains, for example), went to the student parties (but did not drink or smoke marihuana) and was known to like small pretty girls. Some girls found him to be a "slimeball" while others recalled how he helped them academically and through counseling when they were under stress. When questioned later, Epstein refused to answer a question about whether he ever had sex with students there.

A woman whom Epstein liked while at school and kept in touch with said that she did not like what Epstein had become when he was working at Bear Stearns. He became arrogant and difficult to deal with.

Epstein's Suicidal Behavior in Prison

Initially, after his arrest on July 6, 2019, he was imprisoned in the Metropolitan Correctional Center in New York City with a cellmate, Nicholas Tartaglione. He was found injured and semi-conscious on the floor of his cell at 1:30 am on July 23. His cellmate said that he did not know what had happened. Correctional staff judged it to be a suicide attempt but it could have been an assault. Epstein was placed on suicide watch for six days.

Tartaglione found a suicide note in a book in the cell which read: "They investigated me for months - FOUND NOTHING!!! It is a treat to be able to choose one's time to say goodbye. Watcha want me to do - Bust out cryin!! NO FUN - NOT WORTH IT!!"

On July 29, he was taken off suicide watch and placed in a different cell with another inmate. On the night of his death, his cellmate was removed, and the staff failed to check on Epstein every half hour as required because they fell asleep. The cameras in the unit were not working properly. Epstein was found dead in his cell at 6:30 am on August 10, 2019. The autopsy found that Epstein sustained breaks in his neck bones, including the hyoid bone, which indicated that either Epstein had jumped with a rope of some kind around his neck from a height or strangulation. Two days earlier, on August 8, Epstein had signed a will.

As noted above, many people have decided that Epstein was murdered, and his death was thought to have saved many men from scandals who were rich enough to have paid for his murder. However, the release of the Epstein files from the Department of Justice has brought them into the public eye and ruined their careers.

Comment

Epstein's life after leaving teaching at the Dalton School put him in the company of rich businessmen and beautiful women. He made millions, with brief episodes of being hard-up, but ended up very rich. He was close to many beautiful women, but something made him stand aloof.

In the case of Eva Andersson, their relationship was serious and romantic. He encouraged her to finish medical school and helped her with tuition, and she became a doctor of internal medicine. Their relationship lasted nine years (1981-1990), but he did not marry her. One friend said that he did not want children, but there was something in his personality that made him want to be independent from a wife. Yet there is nothing in his childhood or his parents' marriage that we know of that might have caused this behavior.

Many of the men he associated with were unethical in financial matters, but not that we know of in matters outside of business. They were rich and used to having their own way, and probably had affairs and mistresses (and even high class prostitutes) but, apart from those attracted later to Epstein's adolescent victims, his

business partners and associates seem to have been behaviorally normal for men of their wealth.

Epstein was odd, at school and in his early career (perhaps the label *eccentric* fits him), and deviant sexually in his later life, but there is no evidence of any risk factors for suicide until his arrest on July 6, 2019, and subsequent imprisonment awaiting trial. During his first imprisonment, in 2005, Epstein had money and paid other prisoners to ensure his safety from attack. In2019, Epstein's money was reduced (because of the settlements) and because he had limited access to it. It is likely, therefore, that he faced a brutal imprisonment in prison. In addition, the role of shame may have played a part in his decision t die by suicide. If he were tried, convicted and sentenced to prison, he knew that everyone would despise him and look upon him as a very sick individual. Perhaps he could not face that?

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THE MIRROR, THE KNOT AND THE RELATIONAL SELF: A Topological Reading of Narrative Identity in Suicidology

Matias Gay[1]
Understanding Suicidology: Institute for Research & Practice, Halifax, Nova Scotia, Canada

Abstract:

Background: Suicide prevention necessarily relies on direct assessment of suicidal thoughts and behaviors, acute safety planning, and attention to clinically actionable risk. These practices remain indispensable. They do not, however, fully explain how a person's self-experience can become difficult to inhabit when recognition, symbolic meaning, embodiment, belonging, and future possibility lose their ordinary coherence.

Objective: This article develops a topological account of suicidal identity disruption by placing Lacanian mirror theory and topology in dialogue with contemporary suicidology, narrative identity theory, relational models of the self, object relations, symbolic communication, and the Existential Network of Suicidal Identity (ENSI).

Method: A critical conceptual synthesis and theory-adaptation approach is used. The paper distinguishes source concepts from clinical extensions, specifies the epistemic status of each figure, and treats diagrams as heuristic models rather than formal mathematical demonstrations or predictive instruments. Seven figures move from vertical depth metaphors to relational topology, then through the mirror threshold, Möbius strip, torus, cross-cap, Borromean knot, and a clinical formulation map.

Argument: Suicidal crisis may involve more than the accumulation of symptoms or the presence of isolated risk factors. It may also involve a disturbance in the relational forms through which selfhood becomes recognizable, symbolizable, embodied, and narratable. A topological vocabulary clarifies failures of linkage among image, language, body, relation, and world without claiming a universal mechanism of suicide.

Conclusions: A topological approach contributes to suicide studies by shifting formulation from hidden depth alone toward relational organization. Its value lies in disciplined description, not prediction. It offers a clinically restrained

[1] matiasg@live.ca: www.understandingsuicidology.com

vocabulary for narrative foreclosure, relational disconnection, embodied unsafety, symbolic remainder, and the modest conditions under which a person's world may become more inhabitable again.

Keywords: suicidology, Lacan, topology, narrative identity, relational self, ENSI, symbolism, suicide prevention, formulation

Introduction: From Hidden Depth to Relational Form

Suicide prevention is often practiced under conditions of urgency. Clinicians must ask directly about suicidal thoughts, intent, planning, access to means, prior suicidal behavior, intoxication, agitation, psychiatric symptoms, social supports, and immediate safety. These questions matter because prevention requires concrete decisions in real time. At the same time, a large meta-analysis of five decades of research demonstrated that commonly studied risk factors have limited predictive power when treated as isolated indicators (Franklin, et al., 2017). This limitation does not weaken direct assessment. It clarifies why clinical formulation must address not only whether risk markers are present, but how a crisis has become organized for this person at this time.

The present article focuses on a related but distinct question: what kind of relational structure allows a person to remain recognizable and inhabitable to themselves? During a suicidal crisis, the ordinary coordinates through which life is made livable may lose their binding force. The future may cease to open, the body may no longer feel safe to inhabit, belonging may become doubtful, and the self may appear as a failed object before an imagined audience. Classic suicidological concepts already identify portions of this terrain. Shneidman (1993) emphasized psychache and constriction of consciousness. Baumeister (1990) described escape from aversive self-awareness. Van Orden, et al. (2010) formalized the roles of perceived burdensomeness and thwarted belongingness. The Integrated Motivational-Volitional model emphasizes defeat, entrapment, motivational moderators, and the transition from ideation to behavior (O'Connor & Kirtley, 2018). The Narrative Crisis Model situates suicidal narrative within the development of an acute suicidal state (Galynker, 2017; Cohen, et al., 2022).

This article does not propose an alternative risk theory that competes with these models. It proposes a different geometry for conceptual integration. Suicidology has often relied on vertical metaphors: surface and depth, conscious and unconscious, visible presentation and hidden cause. The iceberg in Figure 1 is

used only as a familiar pedagogical shorthand. Freud did not use the iceberg as his own diagram, and his metapsychology was substantially more dynamic than the image suggests (Freud, 1923/1961; Green, 2019). The contrast with topology should therefore not be read as a historical replacement of Freud by Lacan. It is a contrast between two habits of clinical attention: one that searches beneath presentation and another that maps the relations through which self-image, speech, affect, embodiment, desire, recognition, and future possibility hold together or come apart.

Figure 1.

From Iceberg to Topology.

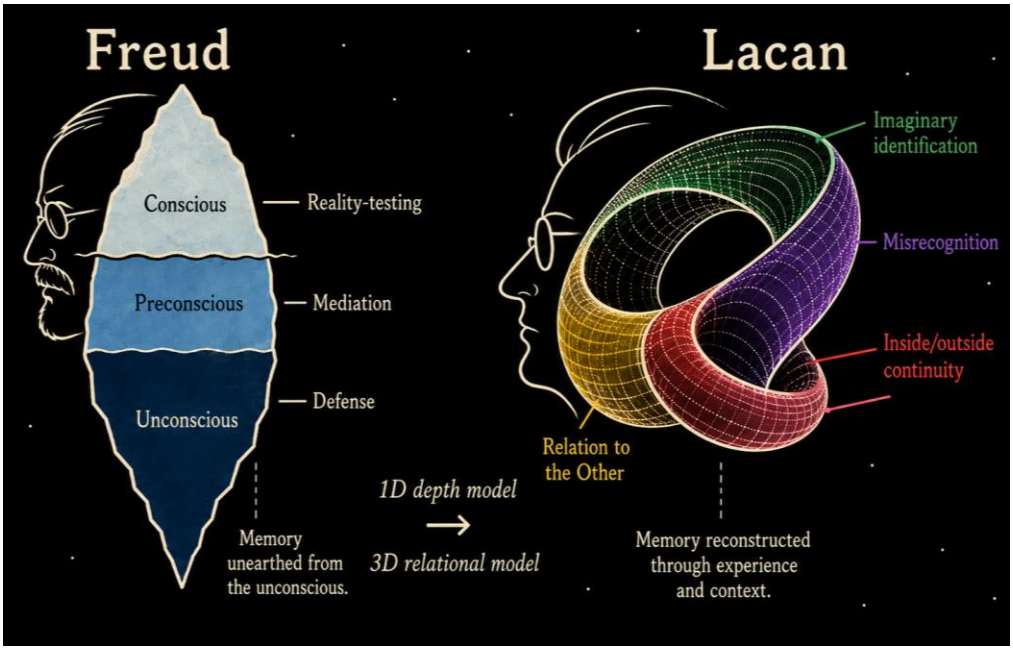


Figure 1 introduces the article's central shift. Topology is not invoked to make suicide theory appear more sophisticated through difficult vocabulary. It is used because particular clinical phenomena are relational in form: the outside becomes internal experience, the future circles around an unresolved absence, language fails to contain affect, and identity depends on linkages among image, speech, body, relation, and world. The figure is schematic. It neither invalidates depth psychology nor claims that a three-dimensional image is a complete model of suicidal crisis.

Conceptual Method and Interpretive Boundaries

This article is a conceptual-theoretical essay rather than a systematic review, clinical trial, or predictive model. Its design is closest to critical conceptual synthesis, theory adaptation, and model development. Established concepts are placed in a new problem context, relations among them are made explicit, and a vocabulary for further inquiry is proposed without implying empirical validation (Whetten, 1989; Jaakkola, 2020). The source traditions were selected purposively because each clarifies a distinct problem in suicide formulation: conflict and depth, recognition and reflected self-image, relational internalization, narrative continuity, embodied affect, symbolic remainder, and the linkage among domains of selfhood.

The argument proceeds through four interpretive operations. First, each topological figure is reconstructed conservatively within Lacan's broader project. Second, the figure is translated into a suicide-relevant formulation question. Third, the translation is compared with established constructs in suicidology, including psychache, aversive self-awareness, burdensomeness, thwarted belongingness, defeat, entrapment, hopelessness, narrative foreclosure, and acute suicidal states. Fourth, each extension is boundary-tested against predictable errors, including the temptation to treat a symbol as a diagnostic code, a diagram as a mechanism, or a relational formulation as a substitute for direct safety assessment. Secondary scholarship on Lacanian topology supports this restrained use (Ragland & Milovanovic, 2004; Greenshields, 2017).

The figures are therefore heuristic maps with an explicitly limited epistemic status. They are not formal mathematical demonstrations. They do not establish that suicidal crises possess a single topological structure. They do not authorize fixed interpretations of images, metaphors, or objects. Their purpose is to make relations visible, identify where ordinary clinical language may flatten complexity, and generate questions that can be examined collaboratively rather than imposed interpretively.

The paper advances five analytic propositions. These propositions are not empirical conclusions. They are disciplined claims for conceptual development and future testing.

- Proposition 1. Suicidal crisis can involve a disturbance in self-recognition, such that available protective facts remain cognitively accessible but lose their felt capacity to bind the person to life.
- Proposition 2. Relational meanings can become internal self-experience without becoming reducible either to intrapsychic pathology or to external social causation.

- Proposition 3. Narrative foreclosure is not equivalent to negative thinking alone. It concerns a narrowing of possible self-continuity, future imagination, and symbolic alternatives.
- Proposition 4. Some clinically significant dimensions of crisis remain embodied, contradictory, or incompletely symbolized. Containment may therefore be ethically prior to interpretation.
- Proposition 5. A clinically useful topological formulation must remain subordinate to direct safety assessment, collaborative intervention, and context-sensitive clinical judgment.

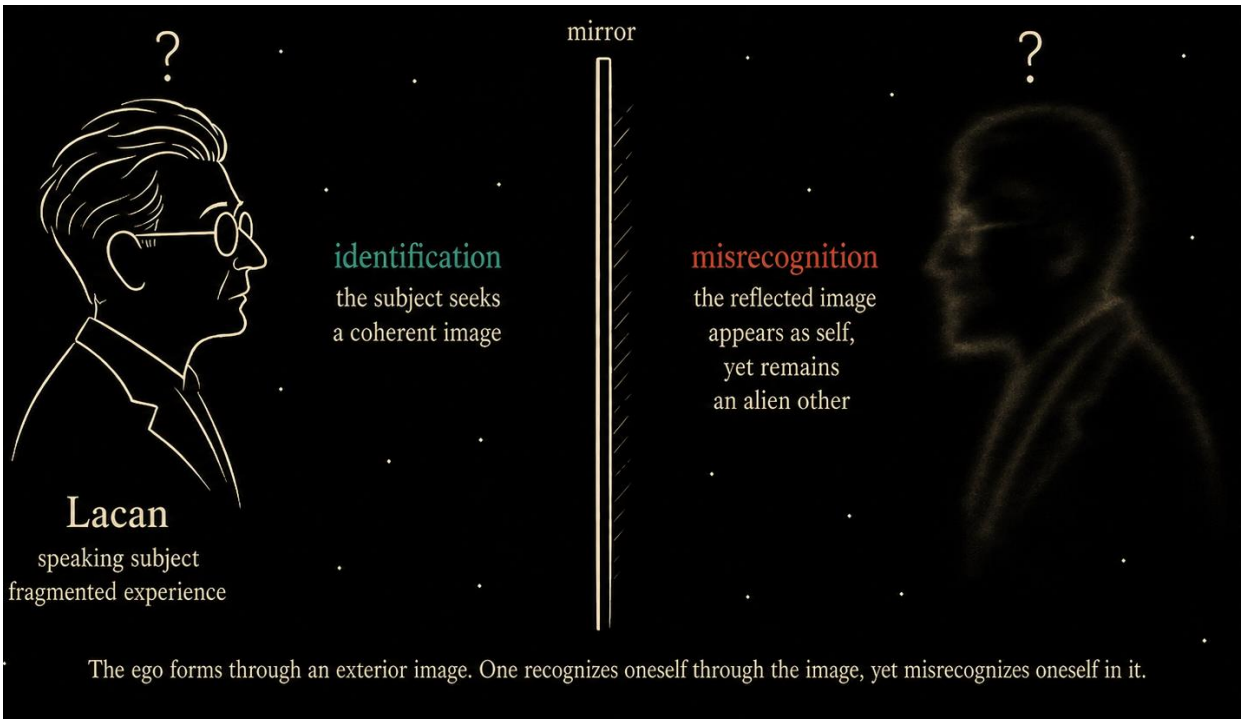
The Mirror Threshold: Recognition and Misrecognition

Lacan's mirror stage offers the first hinge of the argument. The infant identifies with an exterior image of bodily unity before such unity is fully possessed in lived motor experience. The ego is therefore not presented as a transparent interior substance. It is organized through a specular image that arrives from outside and is accepted as "me" through misrecognition (Lacan, 1949/2006). The image is neither simply false nor fully adequate. It grants coherence while leaving a remainder between lived experience and imagined unity. **Figure 2** depicts this threshold as a relation among embodied fragmentation, reflected image, identification, and the gap that persists within recognition itself.

The mirror stage matters for suicidology not because crisis represents a literal return to infancy, but because recognition remains a lifelong condition of selfhood. Contemporary relational psychology similarly argues that self-knowledge is linked with representations of significant others and with the self-other configurations activated in interpersonal life (Andersen & Chen, 2002). People continue to rely on reflective fields that make a self legible: the face of another, the response of a community, the role granted by a family, the language available within a culture, and the stories through which suffering becomes intelligible. When these fields fail, a person may remain alive, thinking, and speaking while struggling to find a form in which the self feels bearable

Figure 2.

The Mirror Threshold



Object relations theory deepens this point without collapsing into Lacanian theory. Winnicott (1971) proposed that the child encounters aspects of the self through the caregiver's face. Bion (1962) described containment as the transformation of affect that cannot yet be thought into affect that can become thinkable. Fonagy, et al. (2002) later described mentalization as the capacity to interpret self and other in terms of mental states. These traditions differ in their premises, but each resists the idea of selfhood as a sealed interior. Self-experience is shaped through reflection, containment, interpretation, and symbolic uptake.

For suicide formulation, the question therefore widens. The clinician does not ask only which symptoms or risk markers are present. The clinician also asks where the person receives a reflection that can be trusted, where recognition has failed, and which image of the self has become intolerable. A statement such as "I am a burden" is not only a belief to evaluate. It is also a relational claim about how the speaker imagines appearing before others. The aim is not to impose a psychodynamic interpretation. It is to explore collaboratively the social, moral, and affective structure already present within the person's language.

Symbols as Vessels of the Self

Symbols matter because dimensions of suicidal suffering do not always appear first as direct report. People communicate through metaphor, repeated phrases, gesture, silence, ritual, creative work, spatial arrangement, and the meanings attached to objects or roles. In symbolic communication, suffering does not automatically become transparent, but it may become formed enough to approach. Clinical attention to symbolism must therefore avoid two opposite errors: dismissing metaphor as ornament and decoding metaphor as though it carried a fixed universal meaning. The relevant question is what a symbol does within this person's narrative, relationships, culture, and present crisis.

Lacan (1953/2006) argued that the unconscious is structured like a language, and his distinction among the Imaginary, Symbolic, and Real helps clarify why symbolic form matters. The Imaginary concerns image, identification, and ego form. The Symbolic concerns language, law, kinship, social order, and the signifiers through which a person becomes recognizable. The Real names what resists complete integration into image and language. It should not be simplified as trauma alone. In the present argument, it marks what remains excessive, bodily, disruptive, or incompletely symbolized within crisis.

Metaphor theory provides a complementary account. Lakoff and Johnson (1980) demonstrated that metaphor structures thought rather than merely decorating expression. Kleinman (1988) similarly showed why illness and suffering must be approached through the meanings by which people render experience intelligible. In suicide formulation, metaphors of weight, enclosure, contamination, exile, drowning, exhaustion, and disappearance may organize how distress is lived. Their importance lies not in a universal code, but in their capacity to reveal how pain, agency, relation, and future possibility have been organized in context.

ENSI provides a suicide-specific vocabulary for this symbolic disturbance (Gay, 2025a, 2025b). Existential identity concerns purpose and the felt possibility that life remains worth inhabiting. Relational identity concerns belonging, recognition, and value to others. Narrative identity concerns continuity, authorship, and possible futures. Embodied identity concerns affective and bodily safety. Primal or proto-self identity concerns vitality and the pre-reflective sense that existence can be endured. Drawn only as layers, these domains risk appearing vertical and compartmentalized. Drawn topologically, they become mutually

dependent dimensions of inhabitation whose clinical significance emerges through relation.

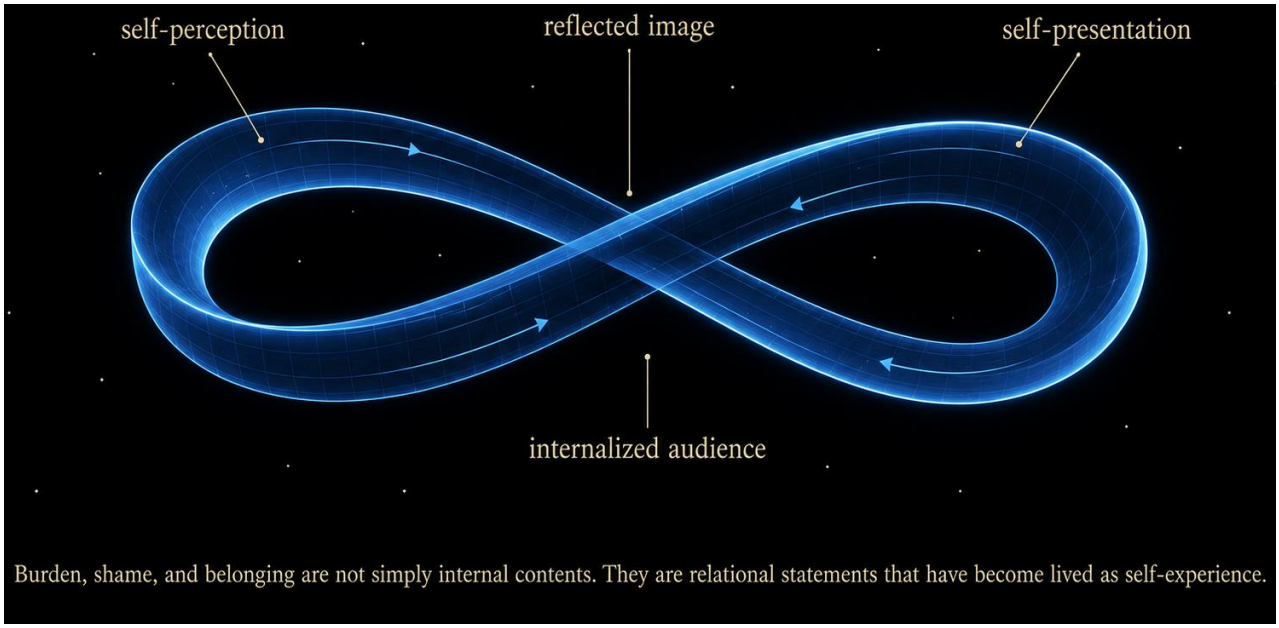
The Möbius Strip: The Relational Self as Continuity With Difference

The Möbius strip is useful because it interrupts the common distinction between inside and outside. A point moving along its single surface arrives on what appears to be the opposite side without crossing an edge. Within Lacanian topology, the strip unsettles the fantasy that psychic interiority can be separated cleanly from exterior relation (Greenshields, 2017). In the present formulation, it depicts how relational meanings can become internal self-experience without ceasing to be relational.

Figure 3 shows recognition as recursive circulation. Self-perception is shaped through reflected image. Reflected image is mediated by responses from others and by the symbolic meanings available within a social world. These meanings become internalized self-experience, which then shapes renewed self-presentation. The sequence is recursive rather than linear, and no single point determines the whole surface.

Figure 3.

The Möbius Strip of Recognition.



This formulation corrects two errors. First, it avoids reducing suicidal identity disruption to internal pathology. A person's self-condemnation may be internally lived, while its grammar has been shaped through humiliation, abandonment, racism, family rupture, bullying, social failure, or repeated invalidation. Second, it avoids dissolving the person into social causation. The self is not merely a passive product of others. The Möbius strip preserves continuity with difference: relational meanings enter the self, while the person also interprets, revises, resists, and presents them.

Clinically, the Möbius strip asks the assessor to listen for folded relational statements. The Interpersonal Theory of Suicide offers an empirically developed vocabulary for part of this terrain through perceived burdensomeness and thwarted belongingness (Van Orden, et al., 2010; Chu, et al., 2017). A sentence such as "Everyone would be better without me" contains a self-image, an imagined audience, a theory of harm, and a moral position. It is not only a cognition to challenge. It is also a relational statement to understand. Intervention may include cognitive work, but it may also require reorganization of the reflective field in which the person sees themselves.

The Torus: Repetition, Desire, and Narrative Time

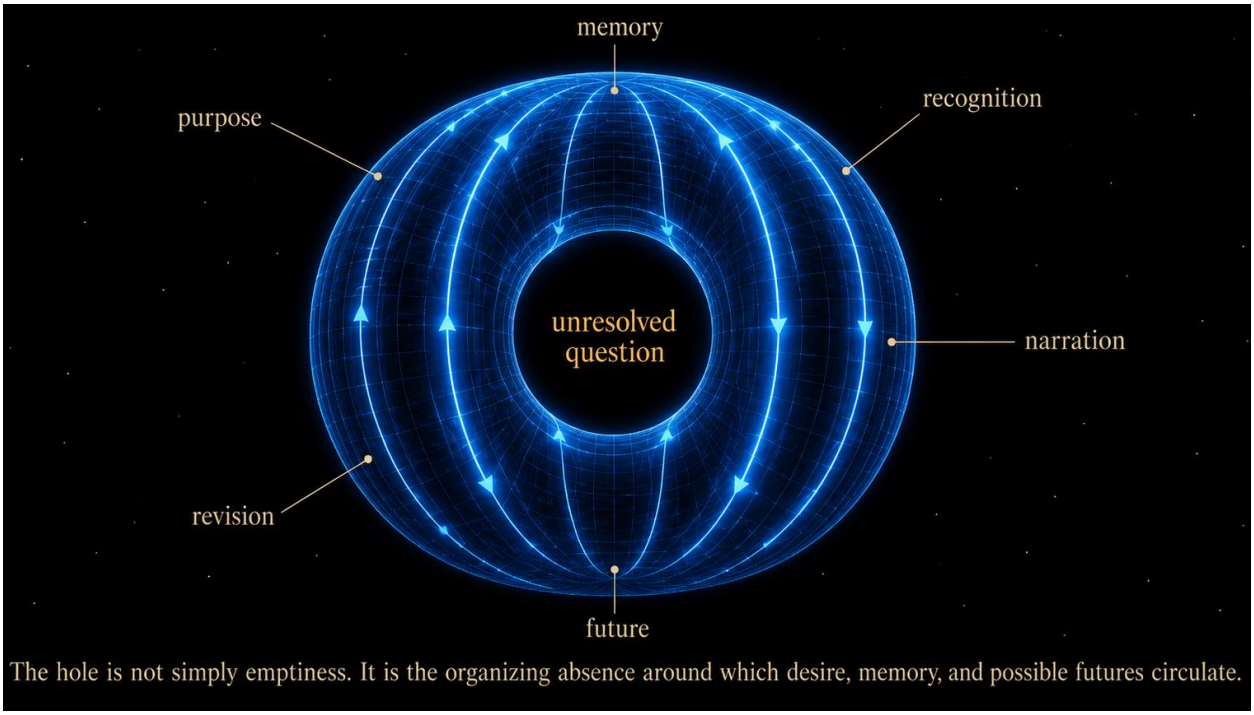
The torus introduces the importance of the hole. A torus is organized around an opening that cannot be removed without changing the form itself. In Lacanian topology, the torus is used to think about demand, desire, repetition, and circuits organized around what cannot be finally possessed or closed (Ragland & Milovanovic, 2004). In the present formulation, it offers a cautious image for how a person may circle repeatedly around an unresolved existential question. **Figure 4** maps memory, recognition, narration, revision, purpose, and possible future as forms of circulation. The central opening is not automatically pathological. It becomes clinically concerning when circulation narrows toward a single imagined exit.

Narrative identity theory clarifies why this matters. McAdams (1993, 2001) described identity as an internalized and evolving life story that provides unity and purpose. McAdams and McLean (2013) emphasized the role of agency, communion, coherence, meaning, redemption, and contamination. Contemporary suicide research provides complementary language. The Integrated Motivational-Volitional model places defeat and entrapment near the emergence of suicidal ideation, while distinguishing those processes from factors associated with movement toward suicidal behavior (O'Connor & Kirtley, 2018; O'Connor &

Portzky, 2018). A topological reading does not replace this model. It asks how entrapment may be lived as a collapse in narrative movement and available self-continuity.

Figure 4.

The Torus of Narrative Circulation.



The torus also distinguishes repetition from mere chronicity. Recurrent crises may not simply represent the return of an identical symptom. They may involve renewed circulation around a wound that has not found adequate symbolic form: a collapsed role, an unanswerable question, a humiliating image, a lost relationship, an impossible demand, or a painful gap between an expected self and an inhabitable self. The clinical task is not necessarily to remove the hole. Some absences cannot be removed. The task may be to restore movement around it so that narrative circulation does not foreclose into one conclusion.

This is where Baumeister's (1990) account of escape from aversive self-awareness, the Interpersonal Theory of Suicide, the Integrated Motivational-Volitional model, and the Narrative Crisis Model become mutually informative. Pain becomes more dangerous when the self is experienced as aversive, belonging and mattering are compromised, entrapment intensifies, and future-oriented imagination narrows. Evidence that the content of positive future thinking is clinically relevant further supports careful attention to how a person imagines what

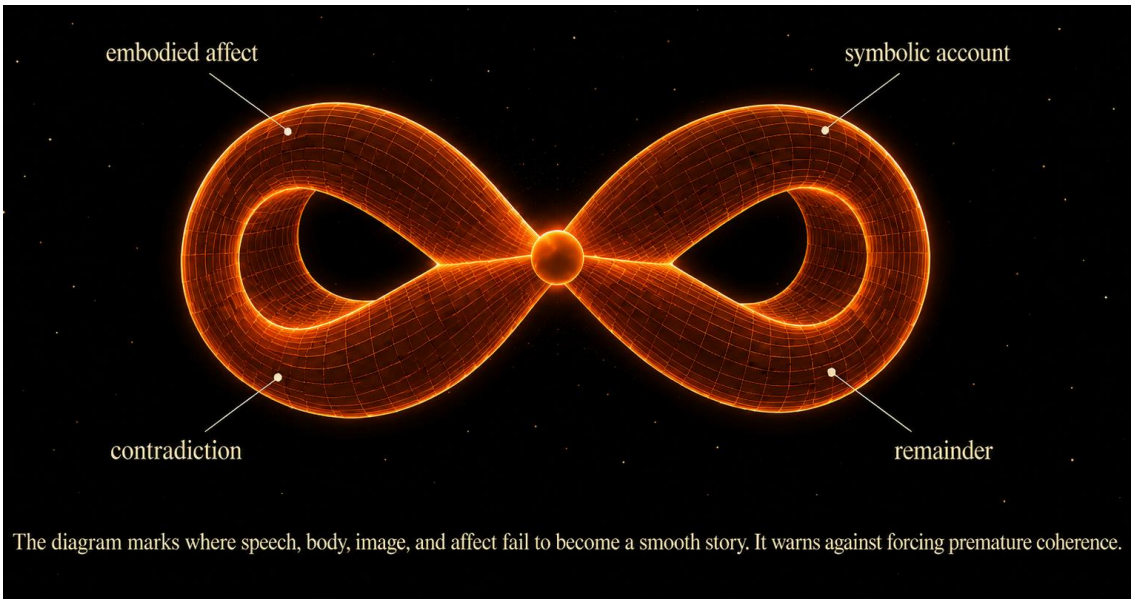
remains possible (O'Connor, et al., 2015). Evidence linking meaning in life with reduced suicidal ideation also supports the importance of purpose without reducing meaning to a simple protective-factor score (Kleiman & Beaver, 2013). The torus gives this convergence a disciplined visual form, not a causal explanation.

The Cross-Cap: Representation, Embodiment, and Remainder

The cross-cap is the most difficult figure in the model and therefore requires the greatest restraint. Its value is not to provide a neat clinical diagram. Its value is to mark the limit of neat diagrams. A cross-cap is a representation of a non-orientable surface whose immersion in three-dimensional space involves self-intersection. **Figure 5** is therefore not a formal mathematical projection and should not be treated as one. It is a deliberately limited visual analogy for moments when distinctions among inside and outside, body and speech, image and affect, or coherence and contradiction no longer hold smoothly.

Figure 5.

The Cross-Cap and the Limits of Representation.



In suicide prevention, this matters because not every meaningful dimension of crisis is immediately narratable. A person may speak fluently while remaining unable to symbolize the affect most relevant to safety. Another may communicate intensely through posture, bodily agitation, withdrawal, or symbolic action without yet having words for the experience. Bion's (1962) concept of containment is

relevant because affect may require relational holding before it becomes thinkable. Mentalization theory similarly cautions that, under stress, the capacity to represent mental states as mental states rather than facts may become unstable (Fonagy, et al., 2002).

The cross-cap also provides a place for ambivalence, defensive organization, and incompletely symbolized experience. A person may seek rescue and concealment, recognition and withdrawal, attachment and escape. ENSI's Controls of Self-Deception can be located here cautiously as defensive efforts to manage contradictions that exceed current integrative capacity. Denial, projection, splitting, repression, and reaction formation should not be treated as codes that reveal a hidden truth. They may be understood as provisional organizations of tolerability.

The clinical warning is important: the assessor should not force premature coherence. A sophisticated interpretation can become harmful when it organizes the clinician more than it helps the person. The cross-cap functions as a limit figure. It protects the model against the fantasy that every image, object, silence, or contradiction can be decoded. Clinically, containment and collaborative safety may need to precede interpretation.

The Borromean Knot: Toward an ENSI Topology

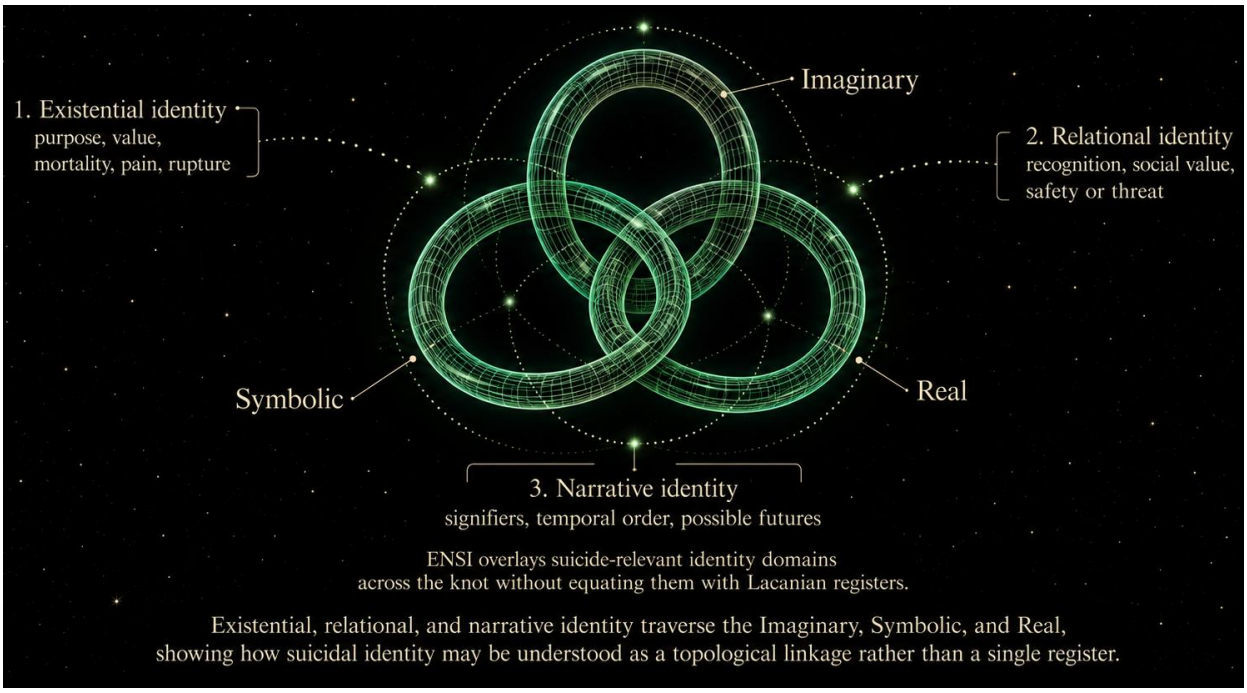
Lacan's later use of the Borromean knot provides the central integrative form. In a Borromean linkage, three rings hold together in such a way that cutting any one releases the others. Lacan used this structure to think about the linkage among the Imaginary, Symbolic, and Real (Lacan, 1975-1976/2016). The Imaginary concerns image and identification. The Symbolic concerns language, law, and social order. The Real concerns what resists complete symbolization. The importance of the knot lies in non-reducibility: no register can be collapsed into another, yet the quality of their linkage matters.

Figure 6 overlays ENSI onto the Borromean structure without claiming that ENSI is a set of Lacanian registers. This distinction is essential. ENSI does not replace the Imaginary, Symbolic, and Real. It specifies suicide-relevant domains of identity that traverse them. Existential identity may require symbolic narratives of purpose, imaginary images of a life worth living, and encounters with finitude, pain, and rupture that resist complete symbolization. Relational identity involves recognition by others, internalized images of social value, and embodied safety or threat. Narrative identity requires signifiers, temporal order, and possible futures, while remaining limited by what cannot be fully said. Embodied identity and the

proto-self remain distributed conditions of inhabitation across the map rather than additional Lacanian registers.

Figure 6.

Borromean ENSI Map.



The article's core claim can now be stated more precisely: suicidal crisis may involve a disturbance in knotting. A person may remain cognitively aware of protective facts while being unable to feel them as binding. They may know that others care while the relational link fails to hold. They may be able to name reasons for living while the future remains experientially inaccessible. This is not a claim that suicidal crisis has one essence. It is a proposal that some crises are illuminated by examining failures of linkage among image, language, body, relation, and world.

This formulation protects against two reductions. First, it resists a purely intrapsychic reading in which suicidal crisis is treated as a private mental event detached from relation and context. Second, it resists a purely social reading in which the person disappears into context. The Borromean model preserves a productive tension: selfhood is neither simply inside nor simply outside the person. It is organized across reflective images, symbolic systems, bodily experience, relational fields, and existential horizons.

Clinical Translation: Listening Topologically

The model becomes useful only if it changes clinical listening. Topological listening does not mean asking clients about Möbius strips, cross-caps, or knots. It means listening for how self-image, language, embodied safety, relational belonging, and future narrative are linked or unlinked. It also means resisting interpretive overreach. The clinician does not arrive as the expert decoder of another person's symbols. Meaning is approached collaboratively, provisionally, and in context. This stance is compatible with suicide-specific approaches that prioritize collaborative identification of the person's drivers of suicidal distress (Jobes, 2012).

Figure 7.

Topological Disturbance and Relational Reopening.

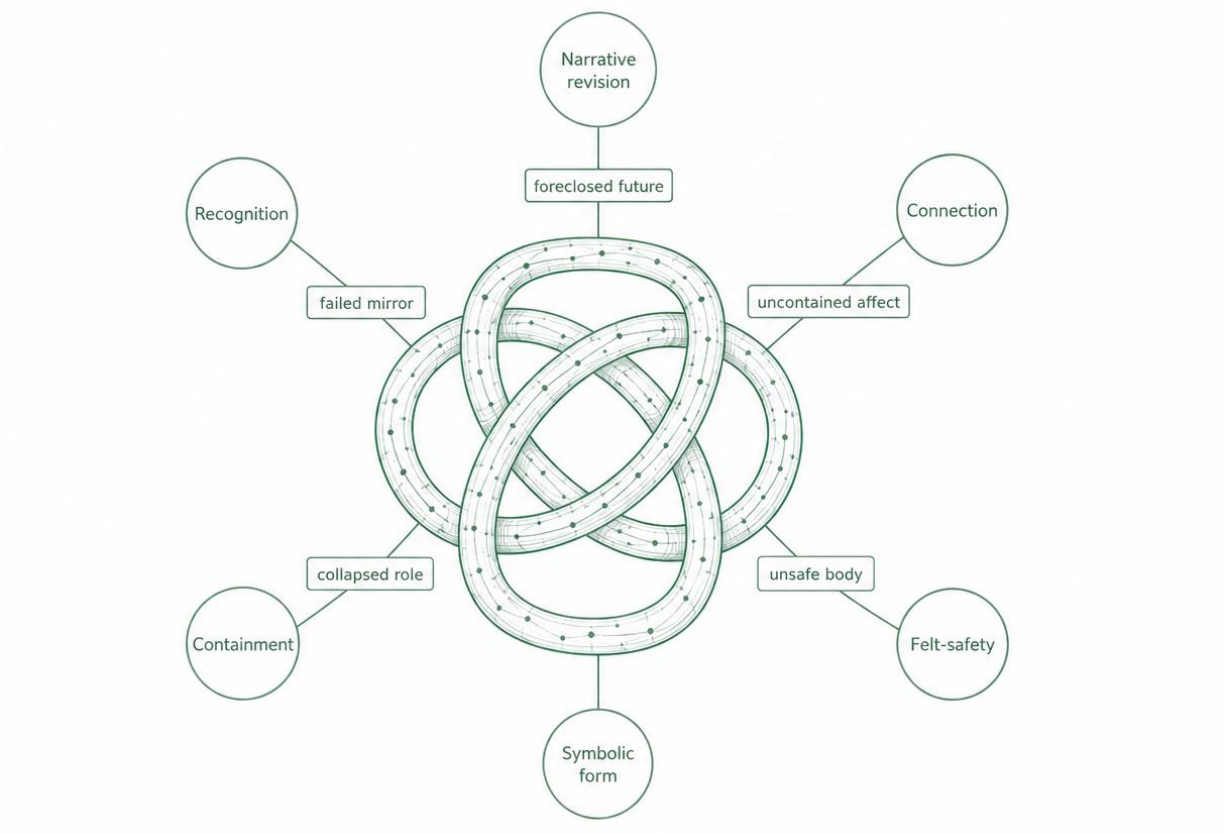


Figure 7 presents recognition, containment, narrative revision, connection, felt safety, and symbolic form as domains of clinical attention rather than

sequential stages or guarantees. The questions are deliberately formulation-oriented. What image of the self has become unbearable? Who is the imagined audience before whom the person appears failed, shameful, harmful, or disposable? Which role has collapsed? What metaphors organize the crisis? What part of the future has become difficult to narrate? What is being communicated through silence, body, setting, gesture, or symbolic action? Where is affect uncontained? Where does the body feel unsafe? What relationship, ritual, phrase, object, place, or practice still helps the knot hold?

These questions fit within existing suicide prevention practice only when they remain subordinate to concrete safety work. They do not replace direct assessment, collaborative safety planning, lethal means counseling, family involvement when appropriate, hospitalization when indicated, or follow-up care. The Safety Planning Intervention provides an example of a practical, collaborative approach that organizes coping strategies and sources of support for periods of elevated risk (Stanley & Brown, 2012). In emergency-department settings, safety planning with structured follow-up has been associated with fewer suicidal behaviors and greater treatment engagement than usual care alone (Stanley, et al., 2018). A topological formulation should deepen understanding of the person's crisis without delaying or displacing these interventions.

The term re-knotting must also be used carefully. It should not imply cure, closure, or the clinician's power to restore a person through interpretation. It refers to modest relational work: offering a reflection that does not intensify shame, containing affect long enough for thought to return, helping a person find symbolic form for what had been difficult to say, restoring contact with a living relationship or value, and keeping the future open as a field of possible narration. The term names a clinical orientation, not an outcome guarantee.

Contribution to Suicide Studies

The contribution of this article is fourfold. First, it introduces Lacanian topology into suicide studies in a clinically restrained manner. Lacan is often either omitted from applied suicide prevention or imported in ways that become unnecessarily obscure. This essay uses topology as a disciplined visual grammar for relational form: surface, fold, hole, self-intersection, and knot. It does not treat topology as decorative complexity, mathematical proof, or evidence of a causal mechanism.

Second, the article advances ENSI by changing its geometry. ENSI can be misunderstood if its domains are drawn only as stacked layers beneath the person. A topological representation presents existential, relational, narrative, embodied, and primal identity as mutually dependent dimensions of inhabitation. A layer model can imply that the clinician should dig downward. A topological model asks the clinician to map relations among image, language, body, world, and future.

Third, the article extends a longstanding tradition in suicide studies that treats suicide as a problem involving pain, meaning, personality, attitudes, relation, and the organization of the self (Lester, 1997, 2014). Its novelty lies not in claiming that topology explains suicide, but in showing how topological figures can discipline attention to relations that may be flattened by vertical or purely symptom-based formulations. Fourth, it offers an explicit research programme. The figures yield propositions, scope conditions, and formulation questions that can be subjected to qualitative analysis, clinical feasibility testing, and comparative evaluation.

Research Program and Criteria for Further Development

The model should be developed through staged inquiry rather than premature claims of validation. First, qualitative studies could examine whether the proposed topological questions identify recurring relational patterns across clinical narratives, suicide notes, psychological autopsy materials, and survivor writing. Such work should use reflexive coding, cultural attention, and explicit procedures for distinguishing participants' meanings from researchers' interpretations.

Second, clinical feasibility studies could examine whether training in topological listening changes the depth, clarity, and collaborative usefulness of formulations without reducing adherence to direct safety assessment. Relevant outcomes might include formulation quality, therapeutic alliance, clinician confidence, documentation quality, and concordance with established safety practices. The goal would not be to predict suicidal behavior from topology, but to test whether the framework improves clinically relevant understanding.

Third, future theory work should identify disconfirming cases. A useful model must specify where it does not add value. Topological formulation may be less informative when immediate risk is driven primarily by intoxication, acute psychosis, severe cognitive impairment, or rapidly changing behavioral conditions that require urgent stabilization. Even in those circumstances, relational formulation may become useful later, once immediate safety has been addressed.

Limitations and Future Development

Several limitations must be named. First, topology is interpretive, not predictive. It should not be presented as a risk algorithm, diagnostic instrument, or evidence that a particular symbolic configuration causes suicidal behavior. The limited predictive performance of many established risk factors and scales makes restraint especially important (Franklin, et al., 2017; Steeg, et al., 2018). Second, the figures are heuristic translations rather than formal mathematical demonstrations. Third, Lacanian concepts are complex and contested. This article uses topology as a disciplined conceptual grammar rather than claiming comprehensive mastery of Lacanian psychoanalysis. Fourth, ENSI remains a developing framework. Its topological extension requires empirical, qualitative, and clinical refinement.

Fifth, the model risks over-intellectualization if separated from clinical practice. Suicide prevention requires humility, immediacy, relational presence, and concrete safety work. A diagram becomes an ethical failure if it distances the clinician from the person. Sixth, symbolic interpretations are culturally situated. A metaphor, ritual, object, role, or silence cannot be assigned a fixed meaning outside the person's context. Seventh, a topological model may privilege coherence as an ideal. The aim is not to produce a seamless self or to eliminate contradiction. It is to identify when disconnection, foreclosure, or embodied unsafety have become clinically relevant and to support conditions in which life becomes more inhabitable.

usefulness against alternatives. Comparative work should examine whether clinicians trained in topological listening produce formulations that are richer, more collaborative, and more context-sensitive without reducing assessment reliability or safety practices. Further theoretical work should clarify relations among topology, narrative identity, mentalization, symbolic communication, embodied regulation, culture, and the ethical limits of interpretation.

Conclusion

This article has argued for a shift from vertical depth alone toward relational topology in narrative suicidology. The self is not only hidden beneath a surface. It is reflected, named, embodied, narrated, located, and linked. Suicidal crisis may become more intelligible when formulation attends not only to the intensity of pain, but also to the conditions that make pain livable or unlivable.

Topology gives suicide studies a language for this linkage. The mirror threshold shows how recognition participates in selfhood. The Möbius strip shows how inside and outside turn into one another without becoming identical. The torus shows how narrative movement may circle around an unresolved question. The cross-cap preserves a place for contradiction and remainder. The Borromean knot clarifies the dependence of image, language, embodiment, relation, and meaning on forms of linkage.

ENSI gives this topology suicide-specific clinical significance. Existential purpose, relational value, narrative continuity, embodied safety, and primal vitality are not separate compartments buried beneath consciousness. They are interdependent dimensions of inhabitation that become clinically intelligible through relation. A person may know they are loved and still be unable to inhabit that knowledge. A person may name reasons for living and still lack an accessible narrative future. A person may speak fluently and still be unable to symbolize what is most relevant to safety.

The final claim is intentionally modest. Suicide prevention is not improved by replacing clinical practice with diagrams. It may be improved when diagrams help clinicians listen more carefully to the forms through which a human life becomes bearable or unbearable. A topological suicidology asks where recognition has failed, where symbols have lost their binding force, where the body has become unsafe, where the future has foreclosed, and where, with sufficient humility and care, relational reopening might begin.

Table 1: Topological Concordance for ENSI formulation

Topological figure	**Clinical question**	**ENSI formulation focus**	**Boundary condition**
Mirror threshold	Where does recognition fail or become unbearable?	Reflected self-image, shame, imagined audience, role collapse	Do not reduce crisis to image alone. Explore meaning collaboratively.
Möbius strip	Where does external response become internal self-experience?	Relational self, perceived burden, belonging, internalized audience	Continuity does not erase agency, culture, or context.
Torus	What unresolved question organizes repetition or foreclosure?	Narrative circulation, entrapment, purpose, possible future	The central hole is not automatically pathology.
Cross-cap	What remains contradictory, embodied, or incompletely symbolized?	Embodied affect, defensive organization, ambivalence, remainder	Use containment before interpretation. The figure is heuristic.
Borromean knot	How do image, language, body, relation, and world hold together?	ENSI domains distributed across linked registers	ENSI does not replace Lacan's registers or establish causation.
Formulation map	Where might relational reopening begin?	Recognition, containment, symbolic form, felt safety, future narrative	Re-knotting is not cure, prediction, or interpretive authority.

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THE ECONOMIC IMAGINATION OF SUICIDOLOGY: A Bibliographic and Thematic Case Analysis of Bijou Yang's Contributions

Matias Gay
Understanding Suicidology: Institute for Research & Practice, Halifax, Nova Scotia, Canada

Author Note: Correspondence concerning this article should be addressed to Matias Gay, Understanding Suicidology: Institute for Research & Practice, 2-1949 Oxford Street, Halifax, NS B3H 4A1, Canada. Email: matiasg@live.ca. The author is a colleague and collaborator of David Lester. This relationship is disclosed as a potential source of positive bias. The manuscript is also written in acknowledgement of the late Bijou Yang, whose career is treated here as a scholarly contribution in its own right rather than as an adjunct to David Lester's. The article includes source limitations, a critical assessment, and a cautious handling of collaboration-count claims to mitigate tribute bias.

Abstract: Bijou Yang's contribution to suicidology has been easy to understate because much of it is embedded within the extraordinary publication record of David Lester. This article argues that Yang should be understood as an economist-suicidologist in her own right. Her Ph.D. training in economics at the University of Pennsylvania under Lawrence R. Klein, her work with the LINK Project, the World Bank, and Wharton Econometric Forecasting Associates, and her long career as a professor of economics at Drexel University gave suicide research a distinctive conceptual instrument: the ability to treat suicide as a phenomenon of macroeconomic stress, constrained choice, labor-market change, social welfare, public cost, behavioral finance, and prevention investment. Using Yang's curriculum vitae, David Lester's publication list current to 2026, and the prior thematic analysis of Lester's corpus as source material, this manuscript presents a bibliographic and thematic case analysis of Yang's suicide-related contribution and of the Yang-Lester collaboration as a sustained married scholarly partnership. The publication-list audit identifies 175 documented Yang/Yeh-Lester numbered entries from 1986 to 2026. Of these, 81 are suicide-, homicide-, violence-, or anomie-related; 119 are economic or behavioral-economic in topic; and 46 sit at the explicit suicide-economy intersection. A decade-level graph, career timeline, conceptual architecture diagram, and thematic heatmap show that

the collaboration moved through identifiable phases: entry through labor, violence, and execution research in the late 1980s; a core suicide-economy and ecological modeling program in the 1990s; a behavioral-economics, digital-commerce, financial-behavior, and rational-choice expansion in the 2000s; economic-crisis and personality-economy extensions in the 2010s; and late archival synthesis through Suicide Studies in the 2020s. The article concludes that Yang's distinctive contribution was not simply to add economic variables to suicide research, but to change the level at which suicide could be interpreted, valued, and argued for as a prevention problem.

Keywords: Bijou Yang, David Lester, suicidology, economics of suicide, behavioral economics, unemployment, economic cost of suicide, rational choice, scholarly collaboration

Introduction: Why Bijou Yang Requires a Separate Analysis

The earlier thematic analysis of David Lester's work was necessarily large because Lester's corpus is large: thousands of publications, more than one hundred books, dozens of themes, and a career that shaped the infrastructure of modern suicidology. Against that scale, an article on Bijou Yang must ask the right question. The question is not simply whether Yang collaborated with Lester, or whether she appears often in his publication list. The sharper question is what type of suicidological imagination became possible because Yang was an economist.

That distinction matters. If Yang is treated only as David Lester's late wife, she becomes biographical background. If she is treated only as a coauthor, she becomes one name in a long collaboration list. But if she is treated as an economist whose work entered suicidology at a specific conceptual point, the picture changes. Yang helped create a suicide-economy program: a body of work that asked how unemployment, divorce, labor participation, economic strain, rationality, violence, cost, digital commerce, credit behavior, and macro-social instability relate to suicidal behavior and suicide prevention.

The present article therefore has two linked purposes. First, it offers a thematic case analysis of Yang's unique contribution to suicidology, especially her background in economics and behavioral economics. Second, it treats the Yang-Lester collaboration as its own scholarly object. The collaboration was not only productive. It was unusually intimate, durable, interdisciplinary, and conceptually coherent. Their married scholarly partnership created a form of cross-disciplinary thinking that neither psychology nor economics could easily have produced alone.

The manuscript is intentionally more than an acknowledgement piece. It is also a corrective to the way academic memory can absorb women into the careers of more publicly visible male partners. A fair account of Yang does not separate her from Lester artificially, because much of the suicide-economy work is genuinely coauthored. But neither does it collapse her into Lester's corpus. The better interpretation is reciprocal: Lester's suicidological breadth gave Yang's economics a humanly consequential domain; Yang's economics gave Lester's suicidology a language of cost, rationality, macro stress, and policy argument.

Design, Sources, and Method

This article uses a mixed bibliographic and thematic case-analysis design. The bibliographic component maps the documented Yang-Lester entries in David Lester's publication list by decade and by broad content category. The thematic component interprets the intellectual contribution of those entries in light of Yang's curriculum vitae and the prior comprehensive analysis of Lester's work. The unit of analysis is therefore not only the individual article, but the research program that emerges when the articles, books, presentations, service roles, and disciplinary biography are read together.

The primary sources are Bijou Yang's curriculum vitae, David Lester's publication list current to 2026, and the prior manuscript analyzing Lester's corpus. The CV provides evidence for Yang's economics education, professional positions, conference presentations, invited talks, awards, editorial work, and behavioral-economics leadership. Lester's publication list provides the available corpus for coauthorship counts. The prior Lester analysis provides the comparative frame: it identified economics and social correlates as one of Lester's major themes, but necessarily treated that theme as one part of a much larger architecture. The present manuscript reverses the lens and makes the economic-suicidological theme central.

The publication-list audit identified entries containing Yang, B.; Yang, B. Y.; Yeh, B. Y.; or B. Y. Lester. It intentionally excluded unrelated collaborators with the surname Yeh. Entries were then coded for three broad flags: suicide-, homicide-, violence-, or anomie-related; economic or behavioral-economic content; and explicit suicide-economy intersection. A second multi-label coding pass assigned entries to ten thematic domains: macro stress and unemployment; labor, family, and social organization; rationality, choice, and irrationality; economic cost and prevention value; violence, homicide, and punishment; behavioral finance and neuroeconomics; digital commerce and consumer behavior;

culture, personality, and economic activity; ecological method and rate structure; and suicide phenomenology or special cases.

The count should be interpreted carefully. The broader collaboration has been described as exceeding 200 articles or scholarly products. The numbered publication-list audit confirms 175 documented Yang/Yeh-Lester entries from 1986 to 2026. The larger figure may be accurate if one includes conference presentations, reports, in-press materials, non-numbered items, and publications from Yang's own complete bibliography. This article therefore distinguishes between the confirmed count from the available publication list and the broader reported collaboration claim.

Table 1. Source base and role in the present case analysis

Source	Use in this analysis	Main limitation
Bijou Yang CV	Education, professional positions, presentations, invited talks, service, editorial roles, awards, and behavioral-economics leadership.	The CV available for this analysis does not include a full standalone publication list.
David Lester publication list current to 2026	Corpus audit of documented Yang/Yeh-Lester publication-list entries and source of representative works.	Self-compiled and not independently bibliometrically validated here.
Prior David Lester thematic analysis	Model for mixed bibliographic/thematic interpretation and comparison to Lester's broader corpus.	Focused on Lester; Yang's contribution was necessarily secondary in that manuscript.

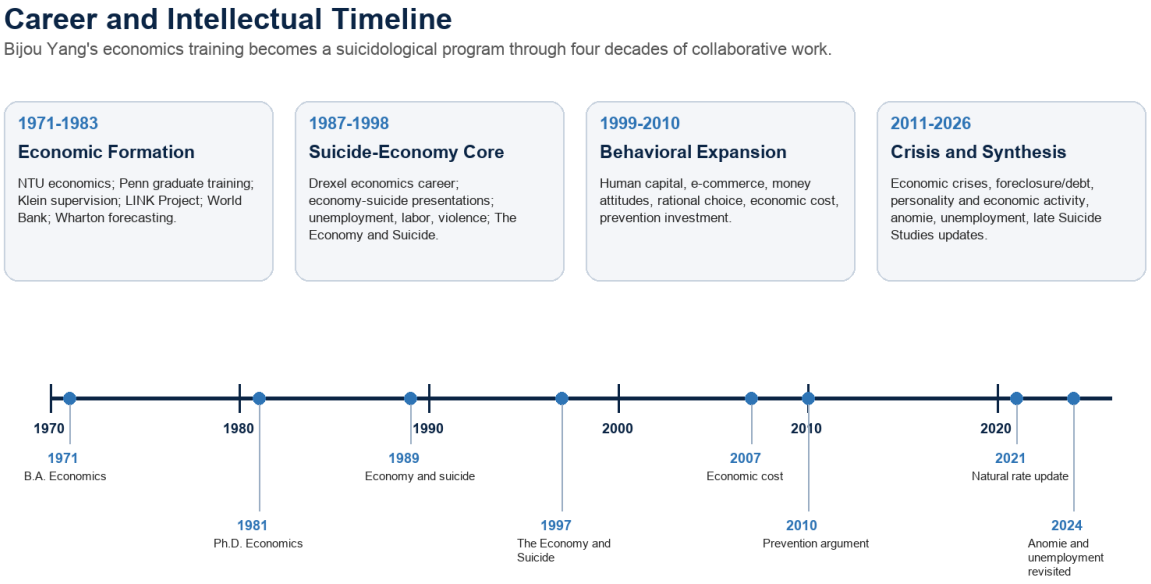


Figure 1. Career and intellectual timeline. Yang's economics training, professional appointments, and suicide-economy publications form a coherent developmental arc rather than a loose set of collaborations.

Biographical Preconditions: The Economist Who Entered Suicidology

Yang's CV begins with economics, and this is analytically decisive. She earned a B.A. and M.A. in economics from National Taiwan University and a Ph.D. in economics from the University of Pennsylvania in 1981. Her dissertation, The Economic Model of Three-Region World, was supervised by Lawrence R. Klein, whose Nobel Prize-winning work in econometric modeling is central to twentieth-century macroeconomics. She also worked with the LINK Project at the University of Pennsylvania, interned at the World Bank, and served as an economist at Wharton Econometric Forecasting Associates before her long career in Drexel University's Department of Economics.

This background is not incidental. It means that when Yang entered suicide research, she brought a professional orientation toward modeling, systems, forecasting, comparative data, policy cost, and social welfare. Suicidology often treats economic variables as contextual correlates. Yang was positioned to treat them as part of the structure of explanation. She could ask whether suicide rates move with macroeconomic pressure; whether unemployment, divorce, labor participation, and social welfare behave differently across demographic groups; whether suicide prevention can be justified through economic cost; and whether

suicidal behavior can be analyzed through rationality, irrationality, and constrained choice.

The CV also reveals that Yang's economics was wide rather than narrow. Her work includes human capital, part-time employment, contingent employment, e-commerce, online purchasing, credit cards, money attitudes, personality and economic activity, rational choice, systemic irrationality, and composite choices. These subjects provide the bridge between formal economics and suicide research. They show that Yang's suicide contribution did not arise from a single topic such as unemployment. It arose from a broader inquiry into how people and societies behave under constraint, uncertainty, valuation, stress, and loss.

Her professional service reinforces the point. Yang served as president of the Society for the Advancement of Behavioral Economics from 2006 to 2008, edited a special issue on behavioral economics in the Journal of Socio-Economics, sat on the editorial board of Suicide and Life-Threatening Behavior from 2004 to 2010, and reviewed for journals across economics, psychology, death studies, and suicide research. In institutional terms, she occupied the borderland between economics and suicidology. That borderland is where her distinctive contribution lies.

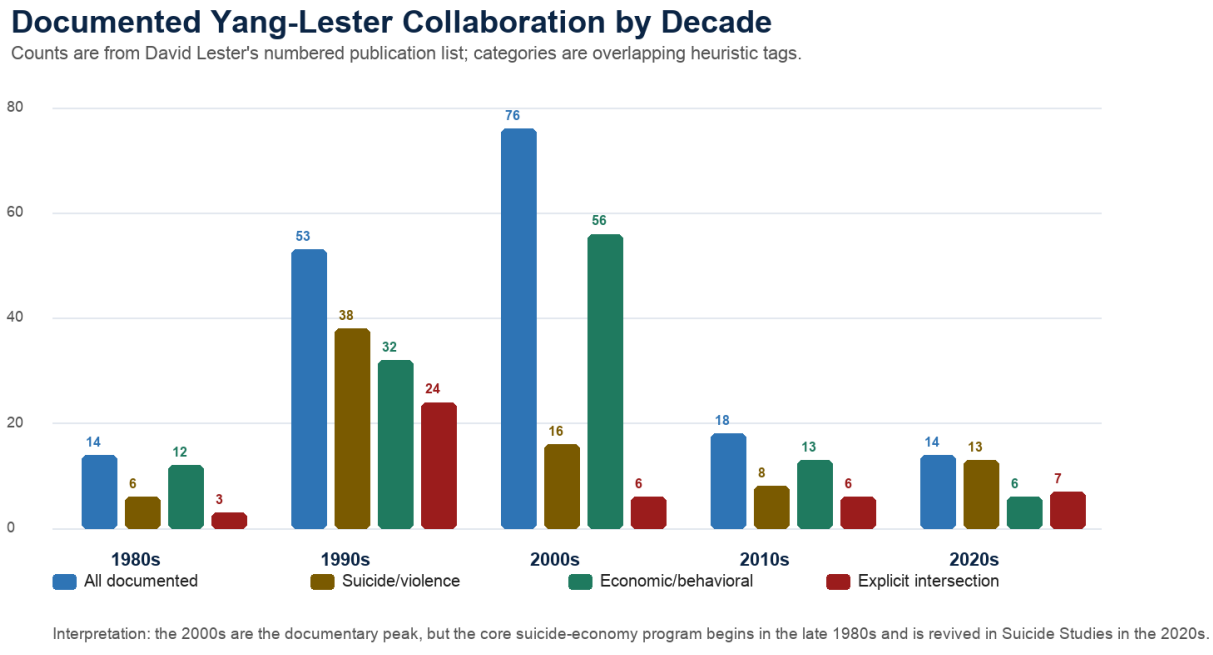


Figure 2. Documented Yang-Lester collaboration by decade. The 2000s show the largest number of documented entries, but the explicitly suicide-economic program begins earlier and continues into the 2020s.

Table 2. Publication-list audit counts by decade

Decade	All entries	Suicide / violence	Economic / behavioral	Explicit intersection
1980s	14	6	12	3
1990s	53	38	32	24
2000s	76	16	56	6
2010s	18	8	13	6
2020s	14	13	6	7

Bibliographic Results: Shape of the Yang-Lester Corpus

The documented Yang/Yeh-Lester corpus contains 175 numbered entries in the available Lester publication list, spanning 1986 to 2026. This alone makes the collaboration one of the most sustained pairings visible in the Lester bibliography. The distribution is uneven: 14 entries in the 1980s, 53 in the 1990s, 76 in the 2000s, 18 in the 2010s, and 14 in the 2020s. The peak in the 2000s is important, but it should not distract from the fact that the conceptual foundations of the suicide-economy program were already visible by 1989-1992.

The 1980s entries show the collaboration entering through labor force participation, working students, divorce, execution rates, death penalty questions, and personal violence. These early topics already demonstrate the couple's shared interest in social organization rather than isolated clinical risk. The 1990s transform that entry point into a genuine suicide-economy program: natural suicide rate, Becker's definition of irrationality, unemployment, economic theories of suicide, elderly suicide rates, economic stress, rational behavior, conceptual economic models, and the 1997 book The Economy and Suicide.

The 2000s are the documentary expansion phase. Yang and Lester move into e-commerce, digital access, online buying, credit cards, money attitudes, prefrontal systems and financial behavior, behavioral economic studies of suicide, economic cost, prevention targeting, and rational-choice critique. This phase matters because it prevents an overly narrow reading of Yang as an unemployment-and-suicide scholar. Her contribution is broader: it concerns how modern economic behavior, decision systems, and psychological valuation relate to social life and self-destructive behavior.

The 2010s and 2020s show consolidation, update, and revival. Economic crises and suicide, foreclosure and debt, personality traits and economic activity, natural suicide rate updates, anomie, unemployment, the economic cost of suicide, and microsocionomics versus macrosocionomics reappear. The late return through Suicide Studies gives the program an archival and reflective quality. It suggests that Yang's contribution is not merely historical; it continues to shape how the couple's older questions were re-read late in Lester's career.

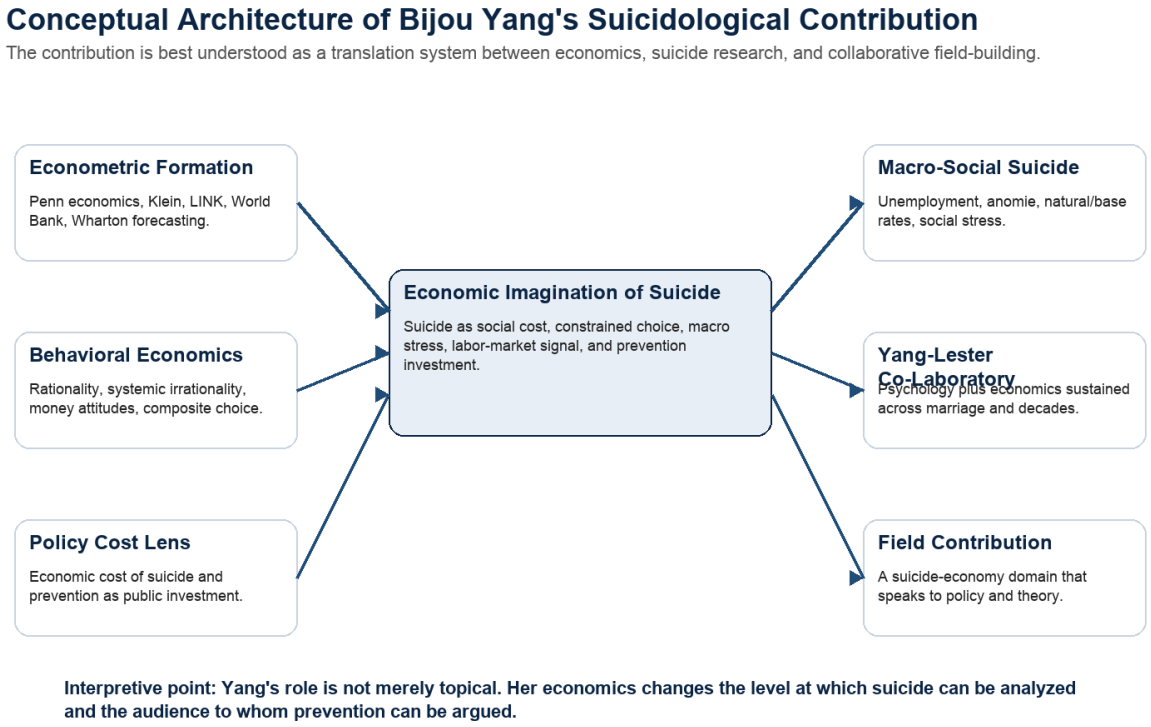


Figure 3. Conceptual architecture. Yang's role is best understood as a translation system linking econometric formation, behavioral economics, and policy cost to macro-social suicide theory and the Yang-Lester collaboration.

Thematic Synthesis: Ten Contributions

The thematic synthesis identifies ten contributions. They overlap; the same entry may belong to more than one theme. That overlap is not a flaw in the coding. It reflects the actual structure of Yang's work, which repeatedly joins economic stress, social organization, decision-making, and population-level suicide patterns.

Theme 1: Macro Stress, Unemployment, and the Economy-Suicide Relation

The center of Yang's suicidological contribution is the proposition that suicide can be studied as an economic and macro-social outcome without losing sight of its human seriousness. Her early presentations on the economy and suicide, the impact of the economy on different social and demographic groups, and the impact of the economy on elderly suicide rates show that she was asking from the beginning whether suicide rates respond to economic conditions in patterned ways.

The published corpus develops this through unemployment, misery indices, economic crises, economic instability, income, and national comparisons. The key insight is not simply that bad economic conditions may increase suicide. The deeper insight is that economic conditions distribute vulnerability unevenly. Different groups experience unemployment, income loss, debt, and recession through different social roles, expectations, resources, and supports. This makes the economy a suicide-prevention issue rather than merely a background variable.

Theme 2: Labor, Family, Gender, and Social Organization

Yang's early work on wives' labor participation, divorce rates, fertility, married men and women, part-time employment, and female labor force participation shows an economist attentive to the household as a social and economic unit. Suicide research has often used marital status or employment status as variables; Yang's work encourages a richer question: how do labor markets and family structures reorganize personal stress, social integration, autonomy, dependence, and exposure to violence?

The 1988 paper on female labor force participation and rates of personal violence is especially important in this respect. It places suicide and homicide together within a larger ecology of gender, labor, and social violence. That pairing is characteristic of the Yang-Lester approach: suicide is not isolated from other forms of personal violence, and economic change is not separated from social role change.

Theme 3: Rationality, Choice, and Systemic Irrationality

Yang's behavioral-economics contribution is most visible in the rationality cluster: Becker's definition of irrationality, rational suicide, economic models of suicide, rational choice, systemic irrationality, composite choices, and two sources

of human irrationality. These works are delicate because the language of rationality can be misunderstood. The point is not to endorse suicide as rational. The point is to ask what kinds of decision distortion, preference collapse, time-horizon narrowing, and constrained valuation may be present when a person chooses death.

This is where Yang's economics becomes psychologically interesting. Classical economic models imagine agents choosing under constraints. Behavioral economics complicates this picture by showing that human choices are bounded, biased, emotionally weighted, context-sensitive, and often internally divided. Suicide can therefore be examined as a decision under catastrophic valuation conditions. That framing connects Yang's work to Lester's later interest in multiple selves and to broader suicidological questions about ambivalence, constriction, and temporality.

Theme 4: Economic Cost and Prevention Value

The economic cost of suicide is one of Yang's most policy-relevant contributions. Recalculating the economic cost of suicide and the later article asking whether there is an economic argument for suicide prevention translate prevention into the language of social value. This is not a cold or reductive move. In policy environments, prevention often competes for attention and funding against other public needs. Economic analysis can help demonstrate that suicide prevention preserves not only lives but also social capacity, family stability, productivity, emergency resources, and community wellbeing.

The significance of this contribution is practical. Moral urgency alone does not always secure prevention investment. Clinical expertise alone does not always persuade budgetary institutions. Yang's cost lens gives suicidology a way to speak to policymakers, economists, and public administrators without abandoning compassion. It says, in effect, that prevention is humane and economically rational.

Theme 5: Violence, Homicide, Punishment, and Social Strain

Yang and Lester repeatedly studied suicide alongside homicide, executions, death penalty policy, deterrence, crime, and personal violence. This theme may appear peripheral to suicide at first, but it is central to their ecological imagination. Suicide and homicide are often treated as separate outcomes, one inwardly directed and the other outwardly directed. The Yang-Lester corpus asks whether both can be read as signals of social strain, social integration, aggression, and institutional structure.

Their death penalty and deterrence work also shows how economic reasoning can enter questions of violence and policy. Deterrence is fundamentally a behavioral and economic concept: it assumes that costs, probabilities, and incentives shape action. By carrying this logic into execution rates and homicide, the collaboration developed a broader theory of how social systems govern or fail to govern lethal behavior.

Theme 6: Behavioral Finance and Neuroeconomics

The financial-behavior strand is one of the reasons Yang's contribution should not be reduced to macroeconomics. Publications on credit card behavior, money attitudes, prefrontal cortex dysfunction, executive personal finance, financial expectations, compulsive buying, debt, foreclosures, gambling, and delayed rewards show a sustained interest in the psychology of economic action. This strand connects economics to neuropsychology, personality, mood, and impulse control.

The suicide relevance is indirect but important. Suicidal crises often involve constricted future orientation, loss appraisal, shame, perceived burdensomeness, and the collapse of alternatives. Behavioral finance studies how people appraise future value, tolerate delay, manage debt, and respond to reward and loss. Yang's financial-behavior work therefore supplies a conceptual bridge between economic life and self-destructive decision-making.

Theme 7: Digital Commerce and the Modern Economy

The 2000s entries on e-commerce, online shopping, buying textbooks online, computer anxiety, digital access, eBay use, PC versus Macintosh users, and attitudes toward online buying may appear far from suicidology. Their importance is that they show Yang studying economic behavior as it was being reorganized by technology. The internet changed markets, consumer behavior, access, identity, and social comparison. Yang and Lester treated these changes as legitimate behavioral-economic objects.

For suicidology, this theme matters because the field increasingly confronts digital life: online harms, cyber-suicide, platform-mediated contagion, and digital forms of isolation and connection. Yang's digital-commerce work was not suicide research in the narrow sense, but it belongs to the same broader question: how does changing economic and technological structure alter human behavior?

Theme 8: Culture, Personality, and Economic Performance

Yang and Lester also examined culture, national character, individualism, competitiveness, personality traits, gross state product, intelligence, economic activity, and economic performance. This theme continues the ecological logic but shifts the emphasis from crisis variables to cultural and psychological context. It asks whether economies have psychological profiles and whether populations display traits that correlate with economic and social outcomes.

This work should be read cautiously because aggregate personality and national-character claims can invite ecological overreach. Still, the intellectual move is important. Yang's contribution encouraged suicidology to think not only about unemployment or recession, but also about the patterned character of societies: their expectations, aspirations, competitive pressures, individualism, and economic norms.

Theme 9: Ecological Method and Rate Structure

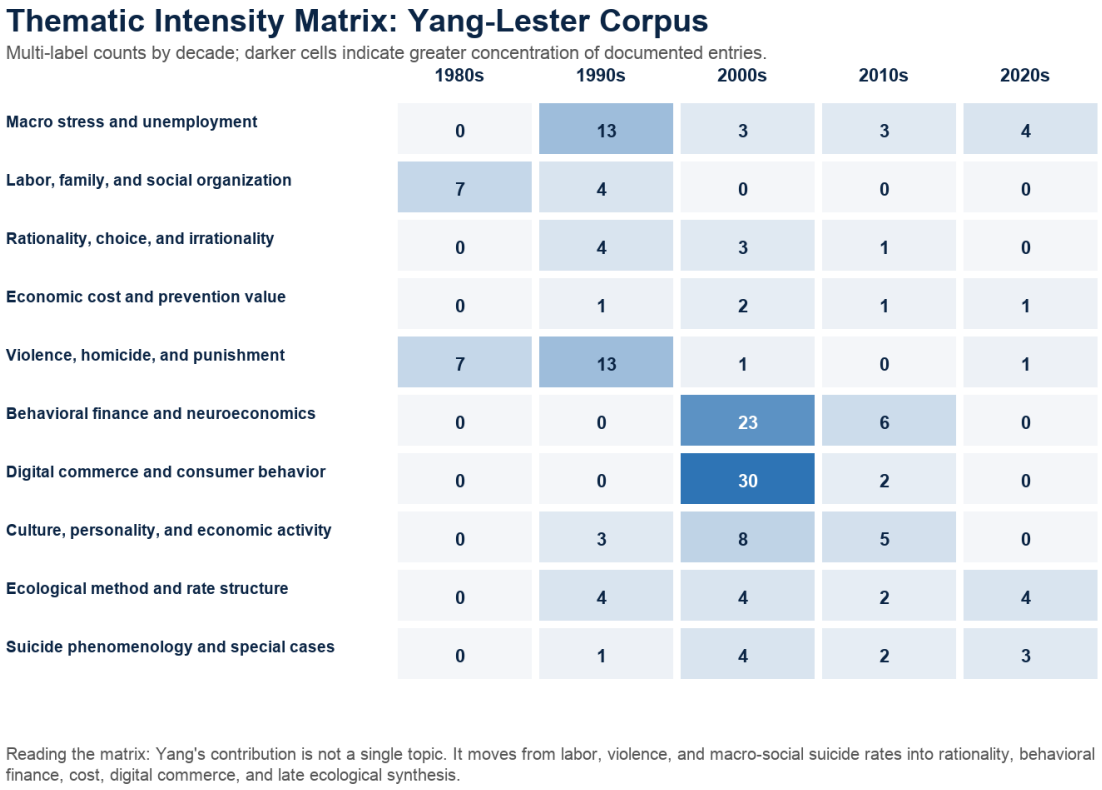
The methodological strand includes time-series analyses, random walk tests, natural suicide rate, base rate, regional and national studies, anomie, and microsocionomics versus macrosocionomics. These works ask whether suicide rates have structure beyond individual aggregation. Is there a base or natural rate for a society? Do rates behave as random walks? Can macro-social variables explain

This theme is where Yang's economics most directly intersects with Lester's ecological suicidology. Economics is comfortable with time series, macro indicators, systems, and aggregate behavior. Lester's suicidology was also comfortable at the ecological level. Together, they built a program that treated suicide rates as social data requiring social explanation. The limitation, addressed later, is that ecological findings cannot be read as individual-level causal mechanisms. But the strength is that they make suicide prevention a societal question.

Theme 10: Phenomenology, Special Cases, and the Human Texture of Data

Although Yang's distinctive contribution is economic, the collaboration was not limited to aggregate variables. Entries on suicide notes, Chinese youths, suicide bombers, smart people, presentation of the self, and suicide in India show that the

work also touched phenomenology, culture, and special populations. These entries matter because they prevent the economic reading from becoming too abstract. The best interpretation is that Yang and Lester held two levels together. At one level, suicide is a rate that can be modeled through unemployment, cost, anomie, or national context. At another level, suicide is a human act with narrative, self-presentation, culture, and meaning. The collaboration's value lies partly in refusing to choose only one level.



Thematic Intensity Matrix: Yang-Lester Corpus

Multi-label counts by decade; darker cells indicate greater concentration of documented entries.

	1980s	1990s	2000s	2010s	2020s
Macro stress and unemployment	0	13	3	3	4
Labor, family, and social organization	7	4	0	0	0
Rationality, choice, and irrationality	0	4	3	1	0
Economic cost and prevention value	0	1	2	1	1
Violence, homicide, and punishment	7	13	1	0	1
Behavioral finance and neuroeconomics	0	0	23	6	0
Digital commerce and consumer behavior	0	0	30	2	0
Culture, personality, and economic activity	0	3	8	5	0
Ecological method and rate structure	0	4	4	2	4
Suicide phenomenology and special cases	0	1	4	2	3

Reading the matrix: Yang's contribution is not a single topic. It moves from labor, violence, and macro-social suicide rates into rationality, behavioral finance, cost, digital commerce, and late ecological synthesis.

Figure 4: Thematic intensity matrix. The matrix shows the movement from early labor/violence/economic stress into rationality, behavioral finance, digital commerce, and late ecological synthesis.

Integrative Analysis: What Yang Added to Lester's Architecture

The prior analysis of David Lester's corpus described his work as systematic pluralism: the refusal to let any single theory, method, or level of analysis monopolize suicide research. Yang's contribution clarifies one important part of that pluralism. She supplied the economic imagination inside the larger architecture. Without Yang, Lester's corpus would still contain economic and

sociological correlates. With Yang, those correlates become a more coherent program of economic modeling, behavioral choice, social cost, labor-market stress, and prevention value.

The difference is subtle but important. A psychologist can include unemployment as a variable. An economist can ask what unemployment means within a system of labor markets, household roles, social welfare, income streams, human capital, expectations, and public cost. A psychologist can ask whether suicide is irrational. A behavioral economist can ask what kind of irrationality is involved, how preferences are distorted, whether choices are composite, and whether the actor's time horizon has collapsed. A public health scholar can say prevention saves lives. An economist can help show prevention as an investment in preserved human capability.

Yang also helps locate the suicide-economy program within a historical moment. Her work moves through late twentieth-century concerns about unemployment, labor force participation, and divorce; into the early internet economy, credit behavior, and financial decision-making; into recession, foreclosure, and economic crisis; and finally into late-career reflection on anomie, unemployment, and ecological method. This is not a static theme. It tracks the changing economy itself.

Her contribution therefore deserves to be named as field-building. It gave suicidology a way to speak across disciplines. Clinicians, sociologists, economists, public health researchers, and policymakers could all find an entry point. In a field where suicide is often framed as either individual pathology or broad social tragedy, Yang's work insisted on a third language: suicide as economically embedded human behavior.

The Yang-Lester Collaboration as Married Scholarly Practice

The collaboration itself deserves analysis because it is not merely a container for the publications. Many academic couples collaborate occasionally. Few sustain a visible specialized corpus across four decades. The documented entries begin in the mid-1980s and extend into 2026. The broader collaboration has been described as exceeding 200 articles or scholarly products. Even the conservative count of 175 documented publication-list entries is exceptional.

The collaboration's intellectual significance lies in complementarity. Lester brought suicidology, psychology, ecological method, cross-national curiosity, and

a willingness to test almost any plausible hypothesis. Yang brought economics, econometrics, behavioral decision theory, labor and family economics, digital-commerce analysis, and policy cost. Their work together created a married interdisciplinary laboratory. That phrase should be used carefully, without sentimental excess, but it captures something real: a sustained household of ideas in which two disciplines repeatedly met.

This has symbolic importance for suicidology. The field studies unbearable disconnection, social isolation, interrupted futures, and deaths that often leave survivors with unanswerable questions. Against that background, the Yang-Lester collaboration models connection as intellectual practice. It shows two scholars returning to difficult questions over decades, translating across disciplinary languages, and allowing personal trust to support professional risk. That role-modeling significance is not separate from the scholarship. It is part of the human ecology from which the scholarship emerged.

There is also a justice issue in how the collaboration is remembered. When one partner is the most prolific figure in a field, the other partner's intellectual identity can be absorbed into the larger name. The present article resists that absorption. It does not claim that Yang's suicide-economy work should be detached from Lester; that would falsify the collaborative nature of the corpus. It claims instead that Yang's presence changed the corpus and that the field should be able to name how.

Acknowledgement: Bijou Yang and the Gratitude Owed to the Couple

This manuscript is written in acknowledgement of the late Bijou Yang. Her career deserves recognition not only because she collaborated with David Lester, but because she brought a distinctive economics-based intelligence into suicidology. She helped the field ask what suicide costs, how economic pressure moves through populations, how labor and family systems shape violence, how rationality fails, and how prevention can be argued as public investment.

The manuscript also expresses gratitude to David Lester and Bijou Yang as a couple. Their collaboration stands out as one of the unusual married scholarly partnerships in suicide research. It was not merely productive; it was generative across disciplines. Their work offers a model for other suicidologists: rigorous without becoming narrow, interdisciplinary without becoming vague, humanly connected without abandoning critical inquiry.

Gratitude, here, is not uncritical praise. It is an acknowledgement that fields are built by people who create intellectual possibilities for others. Yang and Lester created a suicide-economy vocabulary that others can refine, test, criticize, and extend. That is a substantial legacy.

Critical Assessment

A comprehensive account must also be critical. The first limitation is source-based. This analysis relies on a CV and David Lester's self-compiled publication list. These are valuable and unusually rich sources, but they are not equivalent to an independently verified bibliometric database. Further bibliographic work should cross-check the major entries against PsycINFO, Scopus, Web of Science, Google Scholar, PubMed where relevant, and ideally a complete Bijou Yang bibliography.

The second limitation is the ecological level of analysis. Many Yang-Lester suicide-economy studies use state, national, regional, or time-series data. These analyses are valuable for social theory and policy, but they cannot be straightforwardly converted into individual causal claims. A correlation between unemployment and suicide at the national level does not prove that unemployed individuals are the ones dying by suicide. Ecological work is necessary for understanding societal patterns, but it requires careful interpretation.

The third limitation concerns rationality. The rational-choice and irrationality work is intellectually important, but the language can be ethically risky. In clinical settings, suicide should not be casually framed as rational. The more precise argument is that suicidal behavior can be studied through decision-making models because human decisions can be bounded, distorted, temporally narrowed, and socially constrained. This article maintains that distinction clearly.

The fourth limitation concerns influence. The present article argues that Yang's contribution is conceptually significant, but it does not yet prove field-wide impact through citation analysis. Some Yang-Lester works may have shaped the field through Lester's broader corpus, through policy conversations, or through later Suicide Studies re-publication rather than through high citation counts. Future work should distinguish documented productivity, conceptual originality, citation impact, and field uptake.

The fifth limitation concerns the collaboration count. The broader collaboration has been described as exceeding 200 articles or scholarly products, while the current numbered-list audit confirms 175 documented entries. The

difference should not be hidden. It should be resolved by locating Yang's full publication list or by phrasing the claim conservatively.

Conclusion

Bijou Yang's place in suicidology is larger than a brief acknowledgement can show. She was not merely the spouse of a famous suicidologist, and not merely one collaborator in a very long publication list. She was an economist whose work helped suicidology think economically: about unemployment, labor, social integration, rationality, irrationality, human capital, cost, prevention investment, financial behavior, and macro-social structure.

The Yang-Lester collaboration is important because it joined two disciplinary imaginations. Lester's suicidology asked questions at every level of analysis; Yang's economics gave one of those levels unusual depth. Together they built a suicide-economy program that deserves to be treated as a coherent contribution. It is a program with identifiable phases, recurring concepts, book-length synthesis, policy relevance, and late-career renewal.

The field should remember Yang with gratitude and precision. Gratitude recognizes the human and scholarly generosity of the contribution. Precision prevents her from being absorbed into someone else's biography. The strongest claim is therefore not simply that Bijou Yang collaborated with David Lester on many works. It is that her economics altered what that collaboration could ask, what it could explain, and how suicidology could speak to society about the economic conditions and consequences of suicide.

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SUICIDAL IDEATION AND THE FEAR OF DEATH

David Lester
Stockton University
Matias Gay
Understanding Suicide, Nova Scotia, Canada
& Maboubeh Dadfar
Iran University of Medical Sciences

Abstract: In a sample of university students, suicidal ideation measured by item 7 of the Beck Depression Inventory was positively associated with fear of death and several death-related attitudes in zero-order analyses. However, these associations were reduced to near zero after controlling for depressive symptom severity with the suicide item removed. The findings are compatible with the view that fearlessness about death may be more relevant to the transition from suicidal ideation to suicide attempt than to suicidal ideation itself, but they also suggest that the zero-order associations are largely embedded in broader depressive severity.

Surprisingly, there has been little research on the association between suicidal ideation and the fear of death in samples of the general population or students. In a small sample of university students, Lester (1967) found that those who had attempted suicide or who had suicidal ideation had less fear of death.

Those involved in Joiner's (2005) interpersonal theory of suicide have expanded the definition of the construct of the acquired capability for self-harm from experience of pain in the past to include the fear of death. Ribeiro, et al. (2014) developed a seven item scale to measure the fear of death. Typically the scale is used for samples of attempted suicides (e.g., Dhingra, et al., 2015) and not for studies of suicidal ideation in samples of normal people. The present study was designed to explore the association of suicidal ideation with the fear of death.

Method

The sample consisted of 315 Iranian university students (84.8% female) ranging in age from 18 to 84 (M = 25.9, SD = 8.9, Median = 22). Participation was

voluntary and anonymous, and the questionnaires were administered in a single session by course instructors. There were no missing data.

Measures

A new attitude toward death scale (Gay, et al., in preparation). The scale consists of 36 items, nine for each of the four Durkheimian domains (egoistic, altruistic, anomic, fatalistic) based on a proposal by Cox for the attitudes toward death for each domain. Items are rated on 7-point Likert scales from 1 (strongly disagree) to 7 (strongly agree).

The Collett-Lester Fear of Death Scale. The revised scale (Lester, 2004) contains 28 items rated on 5-point scales, seven for each of four subscales: fear of your own death, fear of your own dying, fear of the death of others, and fear of the dying of others. Subscale scores range from 7 to 35.

The Lester Attitude toward Death Scale. The scale (Lester, 1991) contains 21 statements expressing attitudes toward death, administered here with 7-point Likert agreement ratings and scored here as the sum of the items.

The Blustein-Lester Attitude toward Funerals Scale. The scale (Lester & Blustein, 1980) contains 12 items covering attitudes toward the funeral industry (2 items), viewing of the body (3 items), and funerals in general (7 items), administered here with 7-point Likert agreement ratings and scored as the sum of the items (range 12–84).

The Beck Depression Inventory – short form. The 13-item short form (Beck & Beck, 1972) presents groups of statements scored 0–3, with total scores ranging from 0 to 39. Item 7 addresses suicidal ideation with four levels of ideation scored from 0 to 3. Because suicidal ideation was measured from this item, supplementary analyses used a depression severity score computed from the remaining 12 BDI short-form items (i.e., the depression score with item 7 removed).

Results

Table 1 presents Pearson correlations of BDI suicidal ideation with the death-attitude and fear variables, correlations of depression severity (BDI short form excluding item 7) with the same variables, and partial correlations between suicidal ideation and each death variable controlling for depression severity. Spearman correlations for the ordinal suicidal-ideation item gave similar results, so

Pearson correlations are reported for consistency. At the zero-order level, suicidal ideation was associated with greater fear of death and with higher anomic and fatalistic attitudes toward death. However, depression severity without the suicide item showed stronger and more consistent associations, and after controlling for depression the partial correlations between suicidal ideation and the death variables were small and non-significant (all $r \leq .078$). Thus, the zero-order associations should be interpreted as reflecting broader depressive severity rather than suicidal ideation uniquely.

Cox (2005) proposed that egoistic suicides have a low degree of integration in their networks. They do not identify with their social group, nor do they find meaning or purpose in their life from others. These people tended to be the non-religious, the unmarried, and disillusioned, and they focus on their self-interests. These people are likely to be fearful of death.

Table 1: Pearson correlations between suicidal ideation, depression, and fears of death

Suicidal ideation	Depression less item 7	Suicidal ideation partial controlling for depression	
Egoistic attitudes	0.161**	0.337***	-0.078
Altruistic attitudes	0.038	0.139***	-0.068
Anomic attitudes	0.250***	0.376***	+0.011
Fatalistic attitudes	0.295***	0.415***	+0.040
Attitudes toward death	0.124*	0.223***	-0.027
Attitudes toward funerals	0.116*	0.204***	-0.021
Fear of:			
Death of self	0.208***	0.190***	+0.029
Dying of self	0.116*	0.243***	-0.054
Death of others	0.122*	0.184***	+0.004
Dying of others	0.154**	0.201***	+0.033

* two-tailed $p<.05$
** two-tailed $p<.01$
*** two-tailed $p<.001$

Altruistic attitudes toward death would describe individuals who were well integrated into their social groups and view death as something to look forward to. Some elderly people may feel that they have already lived out their lives and are ready for death. Those who believe in a life-after-death may expect their social existence to continue after their death. Others may feel that they are a burden to their loved ones and that their death would lessen this burden. Of course, martyrs may also have an altruistic attitude toward death.

The strongest correlates with suicidal ideation were with fatalistic and anomic attitudes toward death. *Fatalism* involves excessive controls by society over individuals and, therefore, life feels oppressive. Life is mapped out for them without any hope for alternatives. Their future is already decided. Death, like life, may be feared, but at least death offers an escape. Cox thought that risk takers, such as mountain climbers and race-car drives, may also have fatalistic attitudes toward death. It is better to die in this way than in a nursing home.

Anomic people lack constraints and ignore regulations. They may feel anger, disgust and weariness. Their needs and desires may seem to be artificial or trivial to others. They dislike life, but death offers little hope of anything better. Death is simply a way out of an unpleasant existence.

Discussion

At the zero-order level, students who endorsed more suicidal ideation reported greater fear of death and more anomic and fatalistic attitudes toward death. This has a counterintuitive but theoretically useful interpretation, suggesting that fearlessness about death may be more important for the transition from suicidal ideation to suicide attempt than for suicidal ideation itself. In Joiner's (2005) theory of suicide, the act of suicide requires an acquired capability for self-harm, which can develop through experience of physical pain and through reduced fear of death. Thus, people with suicidal ideation may still fear death, whereas those who attempt suicide, especially with greater intent, may have overcome some of that fear. Dhingra et al. (2015) found that university students who had thought about suicide reported greater fear of death than those who had attempted suicide.

The supplementary analyses qualify this interpretation. Depression severity, computed with the suicide item removed, was more consistently related to death attitudes and fears than was suicidal ideation itself, and the partial correlations controlling for depression were close to zero. The most cautious interpretation is, therefore, that the bivariate associations between suicidal ideation and fear of death are largely accounted for by broader depressive severity. The use of a single ordinal BDI item to index suicidal ideation is also a limitation. Future research should replicate these findings with multi-item measures of suicidal ideation, report the distribution of ideation severity, and examine whether fear of death differentiates ideators from attempters.

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AN EMPIRICAL ATTEMPT TO FIND A TYPOLOGY OF SUICIDES: LATENT CLASS AND CLUSTER ANALYSES OF 1050 SUICIDES

Matias Gay
Understanding Suicidology
Institute for Research & Practice, Halifax, Nova Scotia, Canada

& David Lester
Stockton University

Abstract: This examined whether an empirical typology of suicide could be recovered from a Tasmanian dataset containing 1,050 suicides recorded between 1968 and 1987. The analysis was motivated by the argument that suicidology may require typologies before it can develop adequate subtype-specific theories. Forty-one binary indicators covering suicide history, medical and psychiatric contact, psychological state, psychiatric symptoms, and reason codes were analyzed. One- through five-class Bernoulli latent-class models were compared using the Bayesian information criterion (BIC). A companion cluster analysis then tested whether the same case-level indicators produced a stable direct partition. BIC selected a one-class latent-class solution, and cluster analyses produced only weak and unstable partitions. The strongest cluster signal was a previous-attempt/psychiatric-contact distinction rather than a broader typology of suicide circumstances. These findings do not show that meaningful types of suicide cannot exist. They show that this archival indicator set is insufficient to justify naming or interpreting distinct empirical suicide types.

Keywords: suicide; typology; latent class analysis; cluster analysis; coronial records

Introduction

A persistent problem in suicidology is whether suicide can be explained by a single general theory or whether different kinds of suicide require different explanatory models. Lester (2024) argued for renewed theory building in suicidology, and later work has directly emphasized the need to examine suicide typologies (Lester, 2025). A typology would be useful only if it did more than sort

cases descriptively: it would need to identify reproducible groups that are internally coherent, externally interpretable, and useful for later theory testing.

One of the most directly relevant empirical efforts was conducted by van Hoesel (1983), who compared ten proposed typologies of suicide. Judges assigned suicide cases to the proposed types, and the resulting assignments were statistically grouped. Five broad types were identified: escape, confusion, aggression, alienation, and depression/low self-esteem. The types were clinically suggestive, but later application to biographical suicide cases showed that the typology did not classify the cases cleanly. Lester (2026) found that the available biographical cases tended to fit the escape type and that the depression/low-self-esteem category was not useful as a distinct classificatory category.

The present study asks a narrower empirical question. Rather than beginning with an existing theory and assigning cases to pre-existing types, it asks whether a large coroner dataset can generate a defensible empirical typology from recovered case-level indicators. This is an exploratory archival test. The aim is not to prove that no typology is possible, but to determine whether this dataset supports one under transparent model-selection and cluster-validation criteria.

Method

Data Source and Indicators

The data source contained 1,050 records and 61 original variables from Tasmanian coroner records (Haines et al., 2011). The deaths occurred between 1968 and 1987. The variables included demographic factors, method used for the suicide, whether a suicide note was found, suicide history, medical and psychiatric contacts, psychological state, psychiatric symptoms, and coded reasons for suicide. Because the original coding sheet remains unavailable, all analyses were treated as exploratory, and interpretive claims were kept conservative.

The typology analyses used 41 binary indicators covering suicide history, clinical contact, psychological state, psychiatric symptoms, and reason codes. Suicide-note status, demographic variables, and method were not used to define types. This decision kept the typology analysis focused on case circumstances and clinical/psychological indicators, while leaving note status and demographic features available as possible descriptors rather than drivers of classification. Only values coded 0 or 1 were treated as valid binary responses. Invalid or ambiguous values were treated as missing.

Latent-Class Analysis

One- through five-class Bernoulli latent-class models were fitted to the 41 binary indicators. Models were compared using the Bayesian information criterion (BIC; Schwarz, 1978), a widely used criterion for selecting the number of classes in latent-class and mixture-model applications (Nylund et al., 2007). This was not a full Bayesian analysis. Rather, BIC was used as an information criterion with a Bayesian justification and a penalty for model complexity. A multi-class solution would be considered defensible only if it improved BIC and yielded substantively interpretable, nontrivial classes.

Cluster Analysis as a Sensitivity Check

A companion cluster analysis was used as a sensitivity check on the latent-class result. Cluster methods can always force a partition, and so the question was not whether cases could be split, but whether the split was strong, stable and substantively interpretable. The primary cluster analysis used partitioning around medoids with missing-aware Jaccard dissimilarities, appropriate for sparse binary presence/absence indicators where shared absences should not be overinterpreted as similarity (Jaccard, 1901; Kaufman & Rousseeuw, 1990). Candidate two- through six-cluster solutions were evaluated using average silhouette width (Rousseeuw, 1987). Sensitivity checks used simple matching distance, average-linkage hierarchical clustering, a reduced set of more common indicators, and specifications with previous-attempt status removed.

Results

Latent-Class Model Selection

The broad exploratory latent-class analysis did not support a distinct empirical typology. BIC selected the one-class solution, and BIC increased as additional classes were added. Although some multi-class solutions had high entropy, their improvement in log likelihood was too small relative to the additional parameters. Entropy therefore did not override the model-selection result. The LCA result indicates that the current broad set of recovered binary indicators is not sufficient to justify a stable latent-class typology without further variable refinement or original code-sheet clarification.

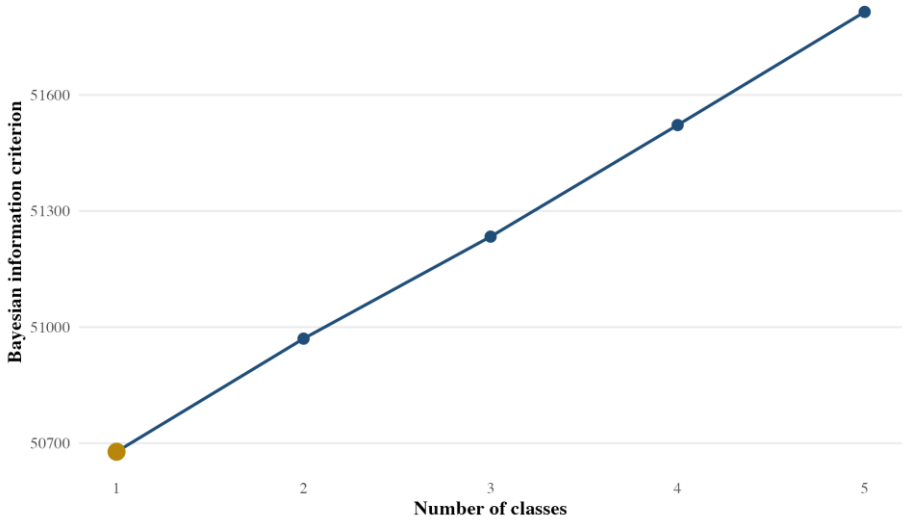
Table 1 gives the fit statistics for the one- through five-class latent-class models, and **Figure 1** displays the corresponding BIC values. Both show the same pattern: the minimum BIC occurred for the one-class model, and each additional class produced a larger BIC despite small changes in log likelihood. Thus, BIC did not support retaining a multi-class typology in this specification.

Table 1: Exploratory latent-class model fit

Classes	Log likelihood	Parameters	AIC	BIC	Entropy
1	-25196.41	41	50474.8	50678.0	
2	-25196.41	83	50558.8	50970.2	1.000
3	-25182.08	125	50614.2	51233.7	0.995
4	-25180.15	167	50694.3	51522.0	0.994
5	-25180.15	209	50778.3	51814.2	0.995

Note. AIC = Akaike information criterion; BIC = Bayesian information criterion. The BIC-selected solution is the one-class model.

Figure 1: Bayesian information criterion for exploratory latent-class models



Note. The highlighted point marks the minimum BIC value.

Cluster-Analysis Sensitivity Check

The cluster analysis led to the same substantive conclusion. The primary two-cluster PAM/Jaccard solution separated 737 cases from 313 cases, but the average silhouette width was only .042, indicating very weak separation. The split was driven mainly by previous-attempt status and related psychiatric-contact indicators rather than by a broad pattern of suicide circumstances. Cluster 1 had no recorded previous attempts and lower psychiatric-service contact, whereas Cluster 2 had high previous-attempt coding (89.9%), recent psychiatric consultation (63.3%), psychiatric hospitalization (61.8%), and psychiatric supervision (47.4%). Suicide-note recording differed little across the two groups (34.4% versus 30.0%).

Table 2 summarizes the key cluster-validation checks. More clusters did not improve the Jaccard PAM solution. Three clusters had an average silhouette width of .002 and larger solutions were negative. Simple matching distance produced a somewhat larger but still weak two-cluster silhouette (.142). When previous-attempt status was removed, the Jaccard solution collapsed into one large group and a small residual group (1,002 and 48 cases; average silhouette width = .016). A reduced common-indicator specification without previous-attempt status produced no usable partition. Hierarchical clustering was not preferable because it mainly isolated very small outlier groups.

Discussion

The central finding is straightforward. This Tasmanian coroner dataset did not yield a defensible empirical typology of suicide. The model-based analysis selected a one-class solution by BIC, and the direct clustering analysis produced only weak, unstable partitions. The convergence of these two approaches is important. It suggests that the negative result is not merely an artifact of one analytic method, but a property of the current indicator set and specification.

The finding should be interpreted as an informative boundary condition rather than as evidence against typology in principle. A typology is an empirical and theoretical claim. It says that cases form meaningful types. The present results do not support making that claim from this sample. The strongest apparent split reflected prior attempt and psychiatric-service contact, a distinction that may partly index clinical visibility and documentation pathways rather than underlying suicide type.

Table 2: Cluster-analysis sensitivity checks

Specification	Distance/method	k	ASW	Cluster sizes	Interpretation
41 indicators	Jaccard PAM	2	0.042	737, 313	Primary solution; very weak separation
41 indicators	Jaccard PAM	3	0.002	739, 172, 139	No improvement over two clusters
41 indicators	Simple matching PAM	2	0.142	736, 314	Same broad split; still weak
41 indicators, previous attempt removed	Jaccard PAM	2	0.016	1002, 48	Collapses into one large group
30 common indicators, previous attempt removed	Jaccard PAM	2	-0.029	1049, 1	No usable partition

Note. ASW = average silhouette width. Values close to zero indicate weak separation.

Several features of the data may have worked against discovering a typology. First, the indicators combine different conceptual domains: prior history, service contact, psychological state, symptoms, and reason codes. Second, some indicators are rare, making them poor anchors for stable classes. Third, reason codes can overlap, and without the original code sheet it is difficult to know whether these codes were intended as mutually exclusive explanations, cumulative circumstances, or post hoc summaries. Fourth, clinical-contact indicators may reflect whether a decedent had entered a service pathway, and not necessarily whether the death belonged to a different etiological type.

Future typology work should therefore proceed differently. It should begin with a theoretically specified set of indicators, keep distal descriptors, such as sex, age, method, and suicide note presence, separate from class indicators, and test candidate solutions against external validators. Any proposed typology should also be checked for stability through resampling or split-sample validation. Access to

the original code sheet would be especially important because it would clarify how symptoms, psychological states, and reason codes were intended to be interpreted.

This contribution is not, therefore, a new typology. It is a cautionary empirical test of whether a broad archival coroner indicator set can support one. The answer, in this specification, is no. That result is publishable because it prevents overinterpretation and defines what would be needed for a stronger future typology study.

Limitations

The study has several limitations. The data were derived from coroners' records and may contain omissions, inconsistencies, or documentation biases. The original code sheet remains unavailable, so some variable meanings must be inferred from recovered variable names and prior publication tables. Missingness was substantial for several clinical-contact variables. The analyses were exploratory and should not be treated as definitive tests of all possible suicide typologies. Finally, the cluster analysis was used as a sensitivity check; because clustering algorithms can force partitions, weak cluster solutions were not interpreted as substantive types.

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WHO USES VIOLENT METHODS FOR SUICIDE? A CAUTIONARY NOTE

David Lester & Janet Haines
Stockton University ***University of Tasmania***

Abstract: In a large sample of suicides, some differences were found for those using violent and non-violent methods for suicide. Those using violent methods were more often male and single and were motivated more often by interpersonal conflicts and stress. However, it is argued that this simple dichotomy of methods for suicide may obscure differences between those using the different methods included in the label *violent*.

Haines, et al. (2010) compared suicides in Australia using different methods for suicide. Those using gas inhalation were reacting to interpersonal conflict or loss and misused alcohol. Those using jumping had ongoing psychiatric problems and a history of suicidal behavior. Those using firearms were characterized by anger and were more likely to engage in murder-suicide. The groups also differed in sex, marital status, employment status, use of medications, drug and alcohol, previous suicidal history, psychiatric and psychological symptoms, and psychological state prior to the suicide and the reasons for their suicide.

More recently, researchers have used a classification of the methods used by suicides as *violent versus non-violent* or as *active versus passive*. Asberg et al. (1976) classified the methods in the following way: violent (hanging, drowning, jumping from heights, use of firearms or knives) and non-violent (self-poisoning, superficial phlebotomy).

For example, Ilgen, et al. (2010) studied veterans with substance use disorders who died by suicide during a four year follow-up. A diagnosis of depressive, anxiety, bipolar and posttraumatic stress disorders, schizophrenia, and personality disorders were associated with increased risk of both violent and nonviolent suicide. These associations were stronger for nonviolent than violent suicide deaths. The risk of nonviolent suicide was greater among patients with opioid-use disorders or a clinical diagnosis of abuse or dependence on multiple substances.

The goal of the present study is to compare the characteristics of those using violent versus non-violent methods for suicide using this classification.

Method

This research studied 1,051 completed suicides from a 20-year period in Tasmania. Information about the cases was obtained from the coroner's inquest files held at the Tasmanian Archives Office and the Tasmanian Department of Justice. All the deaths had been identified by the coroner as being caused by suicide and consisted of all suicides in that period.

Fifty files of suicidal deaths were examined which resulted in suggestions for new variables. These were then added to the original record sheet, and another 50 files of suicidal deaths were examined, and further adjustments made to the record sheet. This new record sheet was then applied to the complete sample of suicides.

Data for the following variables were collected from the coroners' files: marital status, age, sex, living arrangements, employment status, suicide history and stated intention, medical and psychiatric history, psychological state prior to the act, psychological symptoms in the days and weeks leading up to the act, reasons for the suicide, and method of suicide. Two raters coded the data, and their inter-rater agreement was 97%.

Results

The differences between the suicides using violent methods and those using non-violent methods are shown in Table 1. The two groups did not differ in age: non-violent suicides mean=42.27 (sd=15.51) and the violent suicides mean=43.43 (sd=18.72), $t = 0.82$. Those using violent methods were more often single.

The results are surprising in that fact that there were so few differences. The two groups did not differ in their psychological state (13 variables) and significantly in only one of nine psychiatric variables (those using violent methods less often had a sleep disturbance). Those using non-violent methods differed, of course, for eight of the nine toxicologically determined medications/poisons (except for alcohol).

As for the reason for the suicide, those using violent methods for suicide more often had interpersonal conflict or loss and a stressful life event as the reason for their suicide, and they engaged more often in murder-suicide and less often had extrapunitive reasons (punishing others).

Table 1: Differences between those using violent versus non-violent methods for suicide (the numbers are percentages)

Variable	non-violent	violent	X^2	p
Male	60.8	82.5	57.29	<.001
Working	47.1	41.1	3.07	<.10
Marital status				
Single	23.6	36.1		
Married	43.7	38.2		
Divorced/separated	23.6	17.7		
Widowed	9.1	7.9	16.67	p<.001
Previous suicide attempt	33.9	23.6	11.93	<.001
Suicide model	3.2	5.4	2.68	ns
Prior indication	41.1	53.0	12.25	<.001
Recent medical consultation	67.0	58.8	5.22	<.05
Under medical supervision	58.8	52.1	3.40	<.10
General hospitalization	18.9	12.4	5.31	<.05
Recent psychiatric consult.	37.7	33.8	1.23	ns
Under psychiatric super.	28.8	24.2	2.11	ns
Psychiatric hospitalization	365	31.3	2.41	ns
Reason for suicide				
Psychiatric disturbance	37.2	35.7	0.23	ns
Physical illness	29.0	25.7	1.18	ns
Interpersonal conflict/loss	50.7	43.3	5.00	<.05
Social isolation	10.4	9.9	0.06	ns
Stressful life event	28.5	35.3	4.86	<.05
Murder-suicide	0.6	3.1	6.85	<.01
Extrapunitive	3.4	1.2	5.40	<.05
Psychological state				
Normal self	13.2	16.4	1.78	ns
Became upset	27.6	24.3	1.22	ns
Intense distress	10.4	12.7	1,13	ns
Angry/hostile/violent	18.3	22.3	2.20	ns
Sad/tearful/depressed	48.2	48.0	0.01	ns
Withdrawn quiet	15.8	17.3	0.40	ns
Erratic/bizarre behavior	3.7	4.3	0.26	ns
Impulsive/reckless	3.7	3.4	0.05	ns
Confused/absent minded	3.7	4.6	0.54	ns
Unusual sudden cheerfulness	7.0	7.4	0.05	ns
Drunk	32.4	30.3	0.45	ns

Table 1: Differences between those using violent versus non-violent methods for suicide continued (the numbers are percentages)

Variable	non-violent	violent	X^2	p
Changeable moods	6.2	5.6	0.16	ns
Calm/resigned	2.0	1.9	0.02	ns
Psychiatric symptoms				
Agitation	5.4	6.5	0.53	ns
Sleep disturbance	12.4	8.0	4.99	<.05
Withdrawal	5.4	4.2	0.72	ns
Depression	38.9	33.0	3.50	<.10
Anxiety	13.0	12.4	0.07	ns
Hypochondriasis	0.8	1.4	0.57	ns
Suicidal rumination	7.6	6.7	0.32	ns
Psychotic symptoms	5.6	8.0	2.53	ns
Alcohol abuse	20.8	23.1	0.65	ns
Toxicology				
Hypnotics	10.7	0.8	55.50	<.001
Barbiturates	22.3	0.8	137.71	<.001
Minor tranquilizers	11.5	0.6	63.86	<.001
Major tranquilizers	2.8	0.0	18.46	<.001
Anti-depressants	10.1	0.5	53.39	<.001
Analgesics	3.7	0.5	14.92	<.001
Other drugs	10.4	0.6	55.15	<.001
Other poisons	8.7	0.8	41.94	<.001
Alcohol	36.9	33.7	1.04	ns

Discussion

As noted in the Results section, those using violent methods for suicide and those using non-violent methods were more similar than different. They differed in sex and marital status, but not age. They differed in the reason for the suicide, with those using violent methods more often reacting to interpersonal conflict/los and stressful life events, but they were more often single and male which may account for this difference in reasons. The two groups did not differ in psychological state and only in one psychiatric symptom.

In contrast, Lester, et al. (2012) compared males using firearms versus hanging for suicide and found sixteen significant differences including differences in mood (angry, sad, withdrawn and drunk). In addition, those using hanging were more often psychiatrically disturbed. It seems that the classification of the methods used for suicide into violent and non-violent misses important differences between those using each possible method for suicide.

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Suicide Studies, 2026, 7(6), 104-109

HOW TO TALK TO (AND HELP) A SUICIDAL FRIEND OR RELATIVE

Matias Gay, David Lester & Sean Wellington

It is often difficult to respond to a friend or relative who tells us that he or she is feeling suicidal or has attempted suicide in the past. Often we are at a loss for words and experience anxiety. In training people to work as telephone counselors at suicide prevention centers, the trainer typically notes that, when the phone rings with a suicidal caller, there are two crises, one taking place in the caller and one taking place in the telephone counselor. We advise counselors to put aside the fact that the caller is suicidal, and focus on what the situation was that created the crisis.

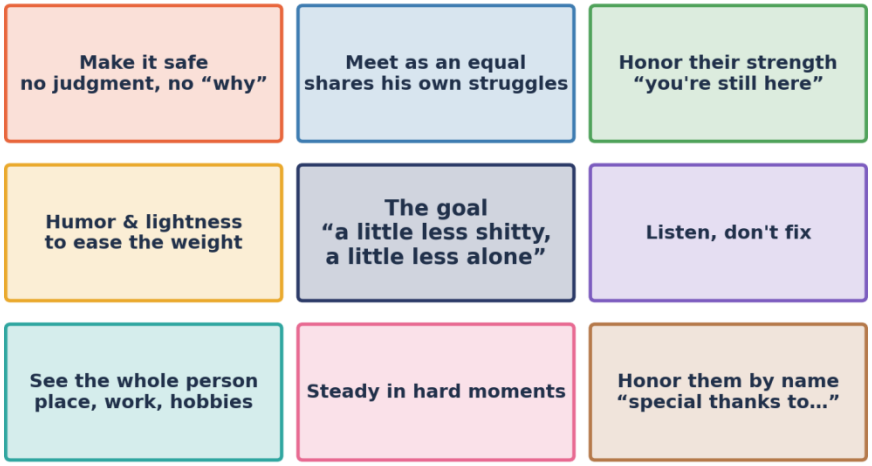
The present essay presents an analysis of the way in one interviewer responds to suicidal individuals: *Suicide Noted (*suicidenoted.com*),* an independent podcast hosted by Sean Wellington that features open, unedited conversations with suicide attempt survivors and those who experience suicidal ideation. Both those who are interviewed and those who listen to his podcast find the interviews helpful. We listened to and read transcripts of a sample of his interviews and coded his responses.

This essay, therefore, looks at the other half of every interview: how Sean holds the space so that people feel safe enough to reveal real thoughts and emotions about suicide. Everything in the colored cards is Sean's own words, taken straight from the episodes. The threads below are simply the moves and manner that come up again and again. None of this is a rulebook. It is a description of a style - warm, curious, honest, and unhurried - that clearly helps guests open up.

The Suicide Noted Way

How Sean Interviews: His Approach and Manner

How Sean Makes It Safe to Speak



1. Make it safe — no judgment, no “why”

Sean sets the tone early: you can say anything, and you will not be judged or reported for it. He even names the questions he chooses not to ask, so guests know where the lines are.

> *“I say I'm all ears if you're willing to share about that.”*
>
> — Sean

> *“One of the things that I'm not supposed to ask is why. Some people feel like it's a judgy question. I don't think I'm coming from that place.”*
>
> — Sean

2. Meet people as an equal

Sean is clear that he is not a clinician sitting above the conversation. He shares his own struggles, which quietly tells guests: we are two people talking, not an expert and a case.

> *“I'm not a therapist, just to be super clear. I talk to people who are attempt survivors.”*
>
> **— Sean**

> *“I have my own battles and struggles and demons, and talking about it invariably helps in some way.”*
>
> **— Sean**

3. Honor their strength

Before anything else, Sean tends to reframe simply being alive as an accomplishment — meeting guests with respect rather than pity.

> *“I look at it as the fact that you're still here. That's enough strength.”*
>
> **— Sean**

4. Humor and lightness

Sean uses gentle humor and self-deprecation to take the pressure off. He teases, laughs at himself, and lets guests laugh too. It never makes light of the pain — it makes the conversation breathable.

> *“Even though I sometimes talk too much …”*
>
> **— Sean, laughing at himself**

5. Listen — don't rush to fix

Sean resists the urge to solve. When he talks about how to help someone in pain, he lands on presence rather than advice — which is exactly what guests said helped them most.

> *“Maybe the right thing to do is, I don't know. Maybe hug them.”*
>
> **— Sean**

6. See the whole person

Sean is genuinely curious about the person, not just the attempt — their country, their tattoos, their hobbies, their pets. It eases guests in and keeps them human throughout.

> *"You'll see the little New Zealand flag there. When you were growing up, was life normal-ish, or hard, or something else?"*
>
> **— Sean**

7. Stay steady in the hard moments

When a guest says something raw or acutely painful, Sean doesn't flinch or over-react. He meets it plainly and honestly, and he is careful not to make false promises.

> *"So this is like an audio suicide note."*
>
> **— Sean, meeting a guest's honesty directly**

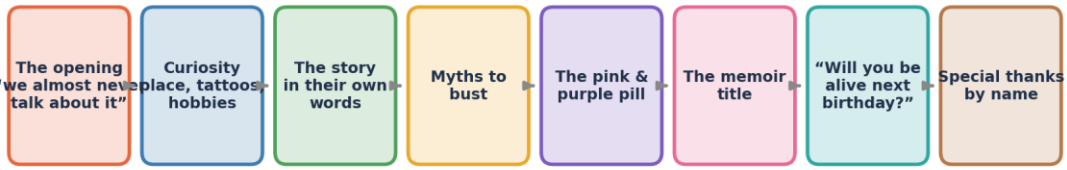
> *"No one's making any guarantees about anything. And if you don't message me, I won't assume you're not here."*
>
> **— Sean**

> *"Are you going to be alive for your birthday?"*
>
> **— Sean, asking gently and directly**

8. The recurring rituals

Regular listeners will recognise the shape of a Suicide Noted interview. These small rituals do real work — they normalise the subject, hand control to the guest, and honour each person by name.

The Recurring Rituals of a Suicide Noted Interview



The rituals, in the order they usually appear.

The ritual	What it is	Sean's words	What it does
The opening	His standard introduction to every episode	*Every year … many millions of people try to take their own lives, and we almost never talk about it*	Names the mission; makes the subject speakable
Curiosity first	Asking about place, tattoos, work, pets	*You'll see the little New Zealand flag there…*	Sees the whole person; eases the guest in
Their story, their way	An open invitation to tell it however they like	*Tell me about your attempt, however you want to frame that*	Hands control to the guest
Busting myths	Inviting guests to correct a misconception	*What are some myths you'd like to call bullshit on?*	Lets guests push back on stigma in their own words
The pink & purple pill	A hypothetical: a painless, private death	*You go to sleep, no pain, you die … would you take it?*	Opens honest talk about wanting to live or die, without judgment
The memoir title	Asking for the title of their life story	*That's a good title*	A creative, humanising turn
"Will you be alive?"	A gentle, direct check-in about the future	*Are you going to be alive for your birthday?*	Honest, caring, and never assumed
Special thanks	Naming the guest warmly at the very end	*Special thanks to … thank you*	Honours each guest as a person

9. The mission underneath it all

When Sean explains why he does this, he keeps it modest and human. The whole style — the safety, the humor, the curiosity, the honesty — serves one simple goal.

> *"Let's help people feel a little less shitty and a little less alone. That's my goal."*
> **— Sean**

Why it works

Put the two reports side by side and they meet in the middle. When survivors described what actually helped them, they named exactly the things Sean does: being treated as a human being, being listened to instead of fixed, being met without judgment, and being honoured as a whole person. In other words, the approach in this report is a living example of the kind of response the survivors said they needed.

What survivors said helped	What Sean does
Being treated like a human being	Meets guests as equals; shares his own struggles
Being listened to, not fixed	"Maybe the right thing to do is … hug them"
No judgment; safe to be honest	"I'm not supposed to ask is why … I'm not coming from that place"
Being seen as a whole person	Curiosity about place, tattoos, pets, work
Being honoured and remembered	Names each guest with warmth at the end

With thanks to Sean, whose steady, warm, and honest way of listening gave these survivors somewhere to be heard — and gave the rest of us the chance to learn from them.

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SPEAKING TO STAY: WHAT SURVIVOR VOICES REVEAL ABOUT DISCLOSURE, CARE, AND REASONBS FOR LIVING

Matias Gay, David Lester & Sean Wellington

Abstract: Suicide prevention often privileges detection, classification, and referral while giving less attention to what people with lived experience say about care usable, and survival imaginable. This interpretive essay develops a de-identified scholarly synthesis of a pre-existing report containing first-person excerpts from 14 guests interviewed for the Suicide Noted podcast. The report organizes the accounts into nine recurring threads. These concerned spoke about act of survival, the difference between disclosure and being understood, the ordinary forms of help that mattered, the responses that failed, the separation of physical safety from dignity, the use of a socially acceptable mask, the personal reasons that sustained life, the rejection of moralizing myths, and the coexistence of hope with continuing suicidal pain. Across the accounts, the decisive distinction was not simply between help and no help. It was between responses that preserved personhood and responses that converted suffering into procedure. Participants described useful care as relational, quiet, practical, accessible and continuous. Reasons for living appeared not as a single protective factor but as a distributed network of people, animals, art, humor, responsibility, and future-directed meaning. The essay argues that suicide prevention must improve not only its capacity to identify risk but also its capacity to receive a suicidal disclosure without erasing the person who speaks.

Keywords: lived experience, suicide, disclosure, dignity, reasons for living, narrative, survivor voices

Suicidology has become increasingly skilled at naming risk while remaining less certain about how to receive the person who discloses it. Clinical systems can screen, stratify, document, and refer, yet a person may disclose suicidal suffering and still leave the encounter feeling unseen. The distinction matters because disclosure is not a completed clinical act. It is a relational event whose meaning depends on what happens after the words are spoken. The first response can widen the space for honesty, or it can teach the speaker that honesty will be met with disbelief, moral judgment, loss of control, or another procedural handoff.

The voices considered in this essay resist the assumption that suicidal experience becomes intelligible once it has been converted into a symptom checklist. Their accounts move between pain and humor, despair and responsibility, concealment and public speech, resentment toward services and gratitude for individual caregivers. They do not present a single pathway into or out of suicidal crisis. Instead, they reveal how survival is negotiated through a changing network of relationships, meanings, practical conditions, and moments of recognition. The central clinical question is therefore not only whether a person has disclosed suicidal thoughts. It is whether the response makes further truth possible.

Research supports the importance of asking directly about suicide and challenges the fear that careful inquiry creates suicidal ideation (Dazzi, et al., 2014). Yet asking is only the beginning. People may withhold suicidal thoughts because of stigma, anticipated overreaction, fear of hospitalization, or loss of autonomy (Richards, et al., 2019). Attempt survivors have also described disclosure as a difficult search for a voice that others can hear without taking ownership of it (Maple, et al., 2020). The present essay stays close to that problem. It asks what these speakers wanted others to understand about speaking, being helped, being kept safe, and remaining alive.

Interpretive Synthesis of the Nine Threads

Nine Threads were identified (see Figure 1).

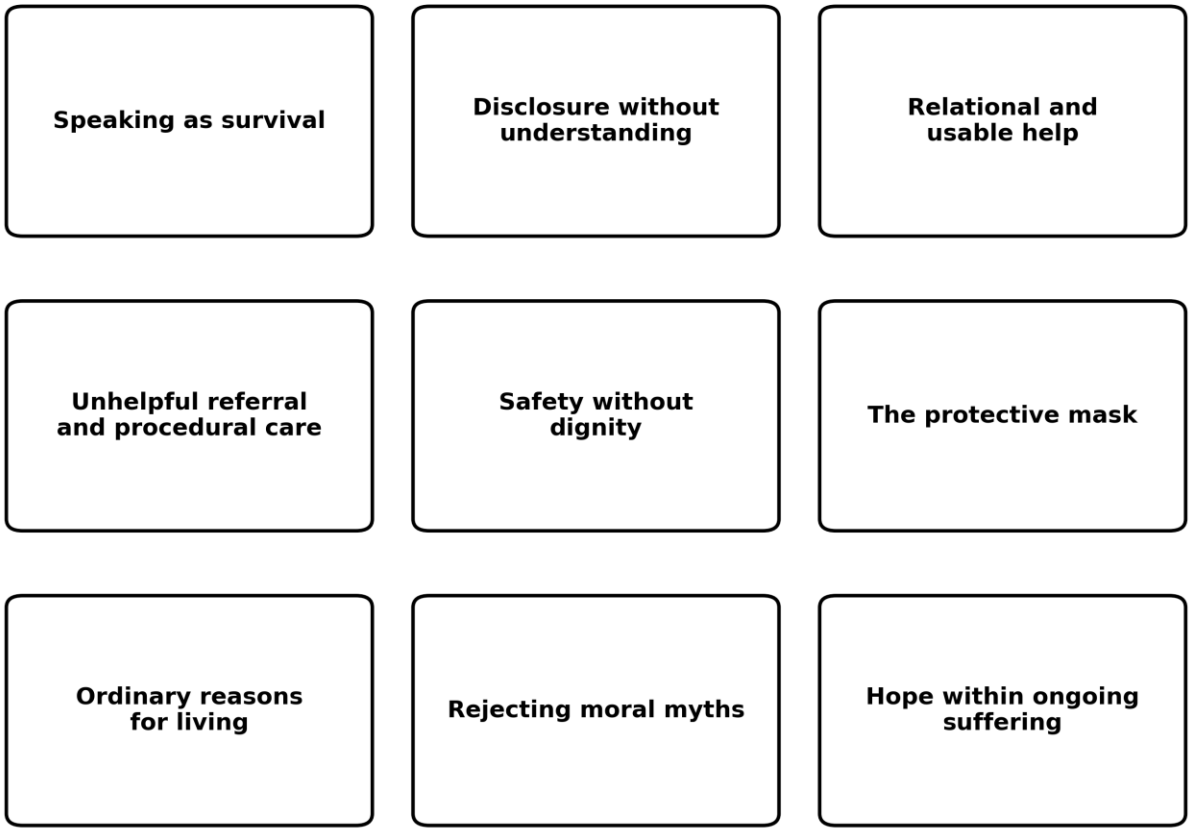
Speaking as Survival and Future-Directed Self-Address

Several speakers described public speech as more than testimony. Speaking was itself part of staying alive. One participant said that hearing others talk openly on the podcast may have preserved their life. Another described the interview as one of the few places where suicidal identity could be spoken aloud without disguise. A third wanted to make the episode for a future self. These accounts position storytelling as an act that moves in more than one direction. It reaches outward toward unknown listeners, but it also reaches forward toward a self who may later need evidence that pain had once been spoken and survived.

> “One of the reasons I want to do this podcast is that I want to make it for my future self.” (P11)

The future self is important here because suicidal crises can collapse time. When the future becomes difficult to imagine, a recorded voice can function as a narrative bridge between selves separated by mood, circumstance, and danger. The speaker does not promise permanent recovery. Instead, the act of speaking creates a trace that can be returned to. Public storytelling may also create a reciprocal form of survival in which one person's account becomes another person's permission to disclose. Research on public narratives of hope has similarly found that helping others is a central motivation for sharing and that storytelling can benefit both speakers and audiences when it is carefully prepared and supported (Kirchner & Niederkrotenthaler, 2024). Experimental and meta-analytic work also suggests that media stories centered on coping and recovery can improve some suicide-related outcomes and help-seeking attitudes (Niederkrotenthaler. et al., 2022).

Figure 1: Nine Recurring Threads across the Survivors' Voices



Note. The figure preserves the nine-thread structure of the source report while using de-identified, academically framed labels.

Disclosure Is Not the Same as Being Understood

The second thread concerned the distance between saying the words and being received. Participants described wearing a mask, appearing functional, and controlling how much others could know. Silence was not always ignorance, denial, or an inability to articulate distress. At times, silence was a deliberate strategy for preserving autonomy. One speaker explained that telling another person might have altered what could be said or done next. Another described exhaustion with a mental health system experienced as broken. In these accounts, nondisclosure was not simply a deficit in the patient. It was partly an appraisal of the likely consequences of disclosure.

> "I am wearing this mask, making myself look like I do not feel anything." (P05)

This distinction is clinically consequential. A person may answer a direct question in the negative because suicidal thoughts are absent at that moment. The same answer may also reflect fear of coercion, stigma, dismissal, or the loss of control that can follow disclosure. Richards, et al. (2019) found that people who did not report suicidal ideation before a later attempt described both genuine fluctuations in ideation and concerns about the consequences of disclosure. Maple, et al. (2020) likewise showed that disclosure during and after suicidal crisis is shaped by whether people believe that others will understand, respond safely, and allow them to retain a voice. The task is, therefore, not merely to extract accurate information. It is to create conditions under which accuracy does not feel dangerous.

Helpful Care Was Relational, Quiet, and Usable

The help participants remembered was often strikingly ordinary. A friend sat nearby without trying to repair the moment. A nurse communicated that the person was still worthy of life. Time away from work created enough space to rest. Family and friends made their presence unmistakable. Another speaker said that being listened to for an hour had provided more recognition than years of prior contact. These were not described as minor gestures. Their apparent smallness was part of their force because they did not require the speaker to perform recovery, gratitude, or coherence before receiving care.

> "The thing that was really helpful was that she just sat with me and did not say anything. I cried." (P01)

> "He was the only person in that building who treated me like a human being." (P08)

The recurring mechanism was recognition. Helpful responses addressed the person before the problem. They did not deny danger, but neither did they allow danger to become the only fact that mattered. This closely resembles the recommendations reported by Hom, et al. (2021), in which attempt survivors emphasized empathy, active listening, reduced stigma, treatment choice, attention to underlying problems, trauma-informed care, accessibility, and continuity. The voices sharpen that finding by showing that usefulness is judged from inside the encounter. A theoretically appropriate service is not useful if it is unaffordable, geographically inaccessible, emotionally intolerable, or offered in a way that strips the person of dignity.

Referral Was Not the Same as Access

Participants drew a clear line between being given a resource and being helped (see Table 1). A crisis line could feel like a wall rather than a bridge. Repeated instructions to call a helpline could communicate that the listener wanted the problem transferred elsewhere. Referrals failed when they required money the person did not have, travel that was not possible, repeated retelling, or emotional effort that exceeded what the crisis allowed. Advice to try harder or remember one's blessings transformed unbearable pain into a moral failure.

> "Most of the time, people tell me to just call the helpline." (P06)

This does not mean that crisis lines, referrals, or formal treatment are inherently ineffective. It means that referral cannot substitute for reception. A resource becomes part of care only when someone helps make it reachable and tolerable. That may involve staying present while a call is made, arranging transportation, reducing cost, explaining what will happen, preserving continuity, or checking back after the referral. The ethical unit of care is therefore not the recommendation alone. It is the pathway from recommendation to actual use.

Table 1: Contrasts between Helpful and Unhelpful Responses

What helped	What did not help
Being accompanied, including in silence	Being told to contact another service with no continued support
Being treated as a person	Being reduced to a burden, diagnosis, or administrative case
Practical support such as rest, leave, transportation, or shelter	Referrals that were unaffordable, distant, or otherwise unusable
Small acts of kindness that were remembered over time	Moralizing advice to try harder or feel grateful
Continuity from someone who remembered the person's story	Repeated handoffs that required the story to be told again

Note. The contrasts summarize the source report and are not frequency counts.

Physical Safety and Human Dignity Were Not Equivalent

Participants distinguished being kept physically safe from being treated well. A hospital admission could contain both protection and humiliation. A restrictive intervention could be remembered as necessary, while another moment in the same system could remain painful because it communicated shame or contempt. Conversely, one compassionate sentence from a social worker or nurse could outlast the larger episode. The voices therefore resist a simple division between good and bad services. They show how safety and injury can coexist within the same encounter.

> "They respected me. A staff member understood an important part of who I was." (P07)

Shame after a suicide attempt is not incidental. Wiklander, et al. (2003) found that shame was prominent in patients' accounts of care and could produce impulses to hide, flee, or avoid treatment. A service may successfully interrupt immediate danger while still weakening the person's willingness to disclose in the future. Dignity must therefore be understood as a safety variable rather than an optional enhancement. Respectful explanation, privacy, collaborative language, and acknowledgment of pain can reduce the sense that the person has become an object managed by others. The question is not whether limits are ever necessary. It is whether limits are enacted in a way that preserves the person's status as a participant in care.

The Mask Protected the Self and Concealed the Crisis

The mask appeared throughout the accounts as a social technology of survival. Participants could attend school, maintain relationships, work, care for animals, and appear outwardly fortunate while feeling profoundly distressed. The mask protected employment, family roles, privacy, and control. It also allowed others to preserve a reassuring story about the person. Yet the same mask made suffering less visible and made the eventual disclosure appear inconsistent with the life others believed they saw.

This theme challenges the moral arithmetic through which visible advantages are treated as evidence against suicidal pain. Family, education, housing, talent, or companionship may matter deeply without cancelling despair. The participant who says that life looks good from outside is not presenting a contradiction that requires correction. The speaker is describing the failure of external biography to capture internal experience. Clinical listening must be able to hold both realities at once. Protective conditions can be present, meaningful, and insufficient.

Reasons for Living were Ordinary, Plural, and Dynamic

When participants described what kept them alive, they rarely named one grand reason. They named a pet, children, family, music, humor, tattoos, art, a friend, a future self, and the possibility of helping someone else (see Figure 2). These reasons were intimate and sometimes fragile. Their power did not come from being universally persuasive. It came from belonging to the person's actual life. A reason for living could be modest enough to appear clinically insignificant and still be decisive at a particular hour.

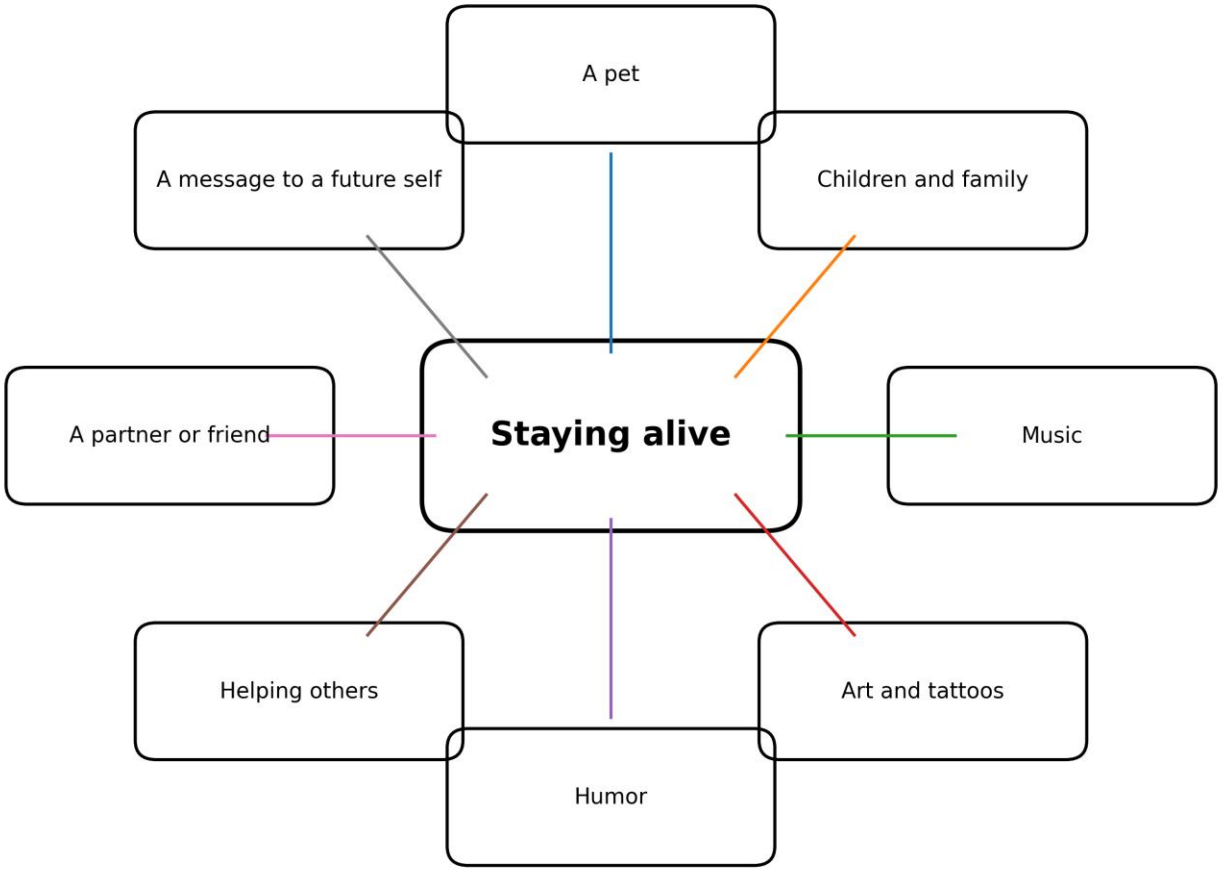
"It is something to look forward to. It is a reason to stay here." (P02)

"I use humor a lot, and it gives me strength." (P12)

It may be more accurate to think of reasons for living as a distributed personal network rather than a static list of protective factors. A single connection may not carry the full weight of survival, but several small attachments can support one another. The network also changes. A pet can create responsibility, music can regulate time, art can make pain visible, humor can restore distance, and a future-oriented project can reopen possibility. Clinical inquiry should, therefore, move beyond asking for one reason to live as though the person must produce a decisive

argument. A richer question is what, or who, still exerts even a small pull toward the next day.

Figure 2: Reasons for Living as a Distributed Personal Network



Note. The reasons identified in the source report were ordinary, personal, and multiple. The diagram represents a network of possible attachments rather than a hierarchy or causal model.

Participants Rejected Moralizing Myths

Participants explicitly rejected descriptions of suicidal people as weak or selfish. Such labels flatten a crisis into a character judgment and erase the intense consideration that many people give to others. The accounts did not ask readers to agree with every conclusion reached during suicidal pain. They asked readers to understand that the person's reasoning often emerges from unbearable suffering,

perceived burdensomeness, hopelessness, or a distorted conviction that others would be better without them. Moral condemnation does not correct these beliefs. It deepens the isolation in which they are held.

> "The myth to dispel is that it is selfish. We spend a great deal of time considering the people who would be left behind." (P10)

The rejection of moral myths was accompanied by a refusal to let suicidality consume the whole identity. One participant emphasized that people living with suicidality are not always miserable and can still experience good moments. This is not evidence that the crisis is unreal. It is evidence that suicidal life remains internally varied. Laughter, affection, competence, and hope can coexist with serious danger. Clinicians and families may miss this complexity when they expect suicidal suffering to appear as uninterrupted despair.

Hope and Ongoing Suicidal Pain Could Coexist

The final thread was the most difficult because some participants spoke from inside the struggle rather than from a completed story of recovery. Their accounts retained fatigue, fear, and a continuing wish not to live. The composed form of an interview did not neutralize the seriousness of what was said. Neither did moments of insight or hope. The voices show why conversational fluency, humor, and reflective capacity cannot be treated as evidence that risk has passed.

> "Every morning I have to find a reason to stay alive." (P05)

At the same time, ongoing pain did not eliminate all attachment to life. Ambivalence was not a transitional flaw that had to be resolved before care could begin. It was the lived condition within which care had to operate. The person could want relief from life and still protect a pet, love a child, make art, speak to a future self, or help an unknown listener. These attachments should not be romanticized or used to pressure the person. They are openings for collaboration. The task is to strengthen what remains connected without demanding that the person deny what still hurts.

Discussion

From Detection to Reception

Taken together, the nine threads identify a central gap in suicide prevention. Systems often concentrate on whether suicidal experience has been detected. These participants concentrated on whether it could be disclosed without losing dignity, autonomy, or personhood. Detection asks whether the clinician has obtained the relevant information. Reception asks what the encounter communicates to the person who provided it. A technically complete assessment can still fail if the speaker leaves believing that honesty produces punishment, disbelief, or abandonment.

The concept of reception also helps explain why apparently small acts were remembered as life-preserving. Sitting quietly, remembering a story, arranging leave, or speaking with warmth may not resemble specialized intervention. Yet these acts alter the relational meaning of the crisis. They tell the person that suffering can be present without making the relationship disappear. They reduce the demand to become coherent before being cared for. In narrative terms, they allow the suicidal account to remain part of a larger life rather than becoming the only story through which the person is known.

Clinical Implications

First, direct inquiry about suicide should be paired with transparent explanation. People need to know why questions are being asked, what may happen next, what choices remain available, and what circumstances would require limits to confidentiality or autonomy. Transparency cannot remove every fear, but it reduces the sense that disclosure opens an unpredictable institutional trap.

Second, clinicians should evaluate the usability of any proposed help. The relevant questions include whether the person can afford it, reach it, tolerate it, understand it, and return to it. A referral that cannot be used is not a completed intervention. Warm handoffs, transportation support, protected leave, follow-up contact, and continuity across services may be as important as the name of the program offered.

Third, dignity should be treated as part of risk management. Language, privacy, tone, explanation, and collaboration shape whether a person will seek help again. Restriction may sometimes be necessary, but humiliation is not. The least coercive safe response should remain the goal, and the person’s account of what feels threatening or stabilizing should inform planning whenever possible.

Fourth, reasons for living should be explored as a network. Instead of asking the person to identify a single sufficient reason, clinicians can map small attachments, responsibilities, pleasures, identities, and future commitments. The network can then be translated into concrete support. A pet may require a temporary care plan. A child may represent connection and also pressure. Music or art may support regulation. Humor may be a strength that should not be mistaken for absence of risk.

Finally, organizations should make room for presence. Intense prevention systems often reward completion, disposition, and documentation more visibly than relational continuity. Yet the accounts suggest that the remembered intervention may be the staff member who remained, explained, and recognized. Services need staffing, supervision, and policies that permit this kind of care rather than depending on exceptional individuals to provide it despite the system.

Conclusion

The survivors' voices do not ask suicide prevention to abandon assessment, crisis services, or safety planning. They ask that these practices remain answerable to the person they are intended to protect. Speaking can be an act of survival, but only when there is somewhere for the speech to land. Help can be clinically appropriate and still unusable. Safety can be achieved while dignity is lost. Hope can be present while suicidal pain remains serious. Reasons for living can be ordinary, unstable, and sufficient for one more day.

The most important shift may be from asking whether the person disclosed to asking what our response taught them about disclosing again. A humane suicide-prevention system must do more than identify danger. It must become a place in which the person can remain recognizable to themselves while danger is addressed. The voices gathered here suggest that people stay not only because someone stopped them from dying, but because someone, somewhere, helped them remain a person worthy of staying alive.

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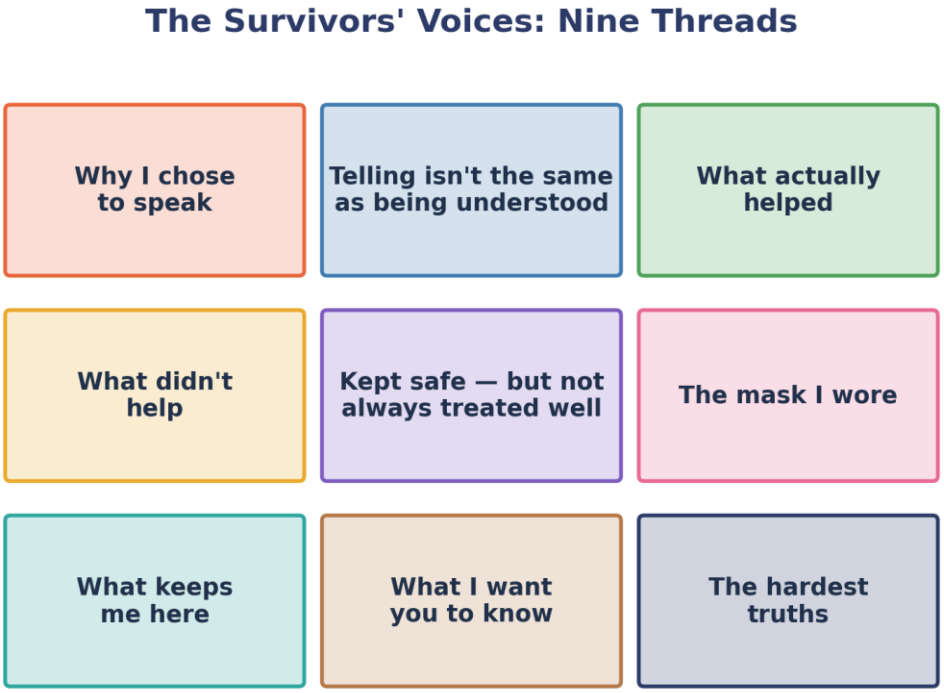
IN THEIR OWN WORDS: THE VOICES OF SURVIVORS OF SUICIDE

Matias Gay, David Lester & Sean Wellington

About This Report

This article is based on guests interviewed for the Suicide Noted podcast. Everything in the colored cards below is a direct quote. We have grouped the quotes into nine simple threads that came up again and again across the interviews. We chose quotes that honor each person — their honesty, their strength, and what they wanted others to understand — rather than the painful details of any attempt.



1. Why I chose to speak

Many guests said the podcast itself was part of why they were still here. Speaking out loud — sometimes for the first time — was an act of survival, a way to feel less alone, and a way to help someone else.

> *"Hearing other people on your podcast talk about this may very well have saved my life."*
>
> **— R**

> *"I feel like it's one of the fewest times of my life that I can loudly say, Hi, my name is Mafusi and I'm suicidal."*
>
> **— F**

> *"One of the reasons that I really want to do this podcast is I really want to make this podcast for my future self."*
>
> **— G**

2. Telling isn't the same as being understood

Saying the words did not guarantee being heard. People described hiding from family while speaking in public, or telling someone and still not being understood. Sometimes silence was a choice — a way to stay in control of what happened next.

> *"I'm wearing this mask, making myself look like I don't feel anything."*
>
> **— F**

> *"The reason I didn't say to anyone is because if I told someone I might try and hold back. I wouldn't be completely honest."*
>
> **— K**

> *“I'm tired of fighting a completely and utterly broken mental health system.”*
> **— A**

3. What actually helped

Over and over, the help that mattered was not grand. It was being sat with, being recognized as a person, being given rest or practical support. What made help useful was whether the person could actually take it in — not how it looked from the outside.

> *“The thing that was really helpful that a friend of mine did for me was she just sat with me and didn't say anything. And I cried.”*
> **— A**

> *“He was the only person in that building who treated me like a human being — telling me that I still deserve to live … you are resilient and you are strong.”*
> **— R**

> *“My PTO has literally saved my life.”*
> **— R**

> *“Everyone just wanted to support me. Everyone just made it as clear as possible that they're here for me. They love me.”*
> **— T**

> *“Just talking about it, having someone listen in the last hour, has been more than someone's done for me in my whole entire life.”*
> **— A**

4. What didn't help

Well-meant responses often missed. A hotline could feel like a wall. Being told to try harder, or being handed a referral that cost too much or was too far away, closed the door instead of opening it.

> *"I called the suicide hotline. They didn't help though — they just made me pissed off. So I didn't kill myself because I was too mad."*
>
> **— L**

> *"Ninety-nine percent of the time … I get people telling me, just call the helpline."*
>
> **— A**

Helped and didn't help, side by side

What helped	What didn't help
Being sat with, in silence	Being told to "just call the helpline"
Being treated as a human being	Being made to feel like a burden or a case
Practical help — rest, leave, a ride, a place to stay	A referral that cost too much or was too far
A small, ordinary kindness that was remembered for years	Being told to try harder or count your blessings
Someone who remembered your story	Being handed off to fill in the form again

5. Kept safe — but not always treated well

People separated two things that are often lumped together: being kept physically safe and being treated with dignity. Sometimes the same hospital stay held both — a shaming moment and a kind one. What people remembered longest was the kindness.

> *"For you to have tried to kill yourself, you must've been in a lot of pain."*
>
> **— words from a social worker**

> *“They respected me. Actually when I was committed I was lucky because one of the members of staff was also trans, so she understood.”*
>
> **— L**

> *“That lockdown was the greatest thing that ever happened to me … if they weren't hard on me, I probably would have just killed myself.”*
>
> **— T**

6. The mask I wore

Many guests looked fine from the outside while struggling underneath. The mask could protect a job, a family, or a sense of control — and it could also keep people from seeing how much someone was hurting.

> *“I have a wonderful family, I have friends, I go to a good school, I'm getting an education, I got a bird. I still feel like shit. And I hate the thought of, I'm not supposed to be this sad.”*
>
> **— B**

7. What keeps me here

When guests talked about what kept them alive, the answers were beautifully ordinary and deeply personal: a pet, a child, a song, a tattoo, humor, a reason to help someone else. Rarely one big thing — usually a handful of small, real ones.

> *“One thing is my bird. He's a very scared bird, Pancho. I've had him for six years now … he's the main reason why I haven't done it yet.”*
>
> **— B**

> *“It's something to look forward to. It's a reason to stay here.”*
>
> **— K on his children**

> *“I use humor a lot, which gives me strength. I laugh at myself all the time … It's dark humor. It's not for everyone.”*
>
> **— S**

> *“The tattoos are a medicine for me.”*
>
> **— Ash, British Columbia**

The everyday, personal reasons guests gave for staying.

8. What I want you to know

Given the chance to bust a myth, guests said the same thing in many voices: this is not weakness, and it is not selfishness. And even in the hardest accounts, people insisted that hope was real.

> *“The myth to dispel is it's not selfish. We spent a huge amount of time considering the other people that are going to be left behind.”*
>
> **— A**

> *“You have to be pretty arrogant to say that somebody's weak or selfish to commit suicide.”*
>
> **— L**

> *“We're not always miserable. We do have good times … I firmly think there is always hope.”*
>
> **— L**

9. The hardest truths

Some guests spoke from inside the struggle, not from the far side of it. These are the voices that matter most to hear clearly. A composed, honest, even hopeful conversation can sit right alongside real, present pain — which is exactly why listening well matters so much.

> *“Right now, I'd like to die because I am tired of fighting this.”*
>
> **— A**

> *“I've been dying for a long time. I feel like every morning I have to find a reason to stay alive.”*
>
> **— F**

> *“The only thing that has kept me from this … is I'm scared of failing again.”*
>
> **— B**

Reading these last quotes can be heavy. They are here because these guests trusted the space enough to be honest, and honesty deserves to be met with care rather than looked away from. If you are one of these voices, or you recognize yourself in them: you are not alone, and support is worth reaching for.

The Voices in this Report

With gratitude to each person who spoke. **Thank you for listening to them.** Their willingness to speak — often sharing what no clinic or service ever wrote down — is the whole reason this report exists.

Suicide Studies, 2026, 7(6), 129-135

A PROPOSAL FOR A TYPOLOGY OF SUICIDES

David Lester
Stockton University

Abstract: In a sample of over one thousand suicides in Tasmania, Australia, Lester and his colleagues found that a good typology of suicides could be based on the method chosen for the suicidal act.

Lester (2024) has long argued that, rather than seeking a theory of suicide, researchers should explore whether a typology of suicides is possible and then whether each type merits a unique theory of suicide. Lester, et al. (2010) examined a sample of 1,050 suicides from Tasmania in Australia with detailed information on the personal characteristics and found differences between those using different methods. Let us look at their conclusions.

Gas Inhalation

People who selected gas inhalation as a method for suicide were likely to have experienced an interpersonal conflict or loss that lead to distress and threats of suicide in the time leading up to the death. There would have been an increasing use of alcohol, including consumption immediately prior to death. The use of alcohol would result in disinhibition, resulting in a suicidal action. There was little evidence of chronic medical, psychiatric or psychological problems prior to death. Despite the interpersonal trigger, there was no particular wish to punish others (extrapunitive motives).An inability to cope without the relationship and the partner, rather than angry or punitive feelings, would have been evident. These themes may have been apparent in the content of the suicide notes that were frequently left by these individuals. The interpersonal conflict, in combination with increased alcohol use, and in the absence of any other specific predictors, seems to be sufficient to result in suicidal behavior in those using gas as a method. Reducing or removing access to the means may enhance the chances that the passage of time and support interventions would resolve these transient difficulties for the suicidal individual.

Firearms

The risk factors for selecting a firearm as a method of suicide were not dissimilar to those associated with gas inhalation although interpersonal conflict or loss was not a strong motivation in these cases. The nature of the interpersonal difficulties for individuals who used a firearm was different and was characterized by anger. The motivation was not extrapunitive in the normal sense of wishing to punish someone in terms of making them psychologically suffer. An inability to cope with anger or a desire to kill both themselves and the perceived offending party may have been more apparent. This view is supported by the inclusion of homicide-suicide as a characteristic of this group. The disinhibiting effects of alcohol, when combined with an angry response, would have lead to a violent outcome. A combination of anger and alcohol could also have resulted in increased impulsiveness which would explain the lack of stated suicidal intent in the time leading up to death. If reactive aggression triggers violence that manifests as suicide and, in some cases, homicide as well, it must be speculated whether managing access to firearms would increase the likelihood that the angry response is handled in some other way such as assault or property damage. These outcomes, although not desirable, are clearly preferable to behaviors that result in the death of one or more individuals. When premeditation is absent, any intervention that extends the time between desire for violence and action, such as making firearms less readily available, could potentially decrease the likelihood of a tragic outcome.

Hanging

There were similarities in the characteristics associated with hanging and jumping from heights as methods of suicide. People who selected hanging as a method of suicide were characterized by having ongoing psychiatric concerns, with anxiety and depression being particularly problematic. There was a heavy use of psychiatric services. The ongoing psychiatric disturbance was the trigger for the suicidal behavior. These individuals had previously attempted suicide. There was little evidence of alcohol being a factor in these cases, and so the disinhibiting effects of alcohol were absent. Further, there was little evidence of anger or extrapunitive intention, and interpersonal conflict and loss were not important factors. There was little indication that there were ongoing medical concerns. Statements of suicidal intention were absent and notes rarely left. There was little evidence of distress leading up to death. The suicidal action appears to have been a more thought-out response to chronic depression. In terms of preventing suicide, it is worthy of note that, among this group, there was no apparent escalation of distress or increased talk of suicide for these chronically depressed and anxious

people in the time leading up to death. It would appear that depression and other common psychiatric symptoms, without additional risk factors being evident, could result in death by hanging. With the access to ongoing psychiatric support available to these individuals, mental health professionals should routinely monitor both suicidal ideation and, because hanging is a solitary activity, should endeavor to increase the availability of support and companionship outside of the therapeutic relationship.

Jumping from Heights

The people who chose to jump from heights as a method of suicide were similar in many ways to those who selected hanging. In particular, they experienced chronic anxiety and were users of psychiatric services. In addition, their psychiatric disturbance was identified as a motive for the suicide. However, in contrast to the people who hanged themselves, those who jumped from heights were not depressed and did not have a history of problems with depression.

Drowning

Drowning, self-poisoning with medication, and self-poisoning with non-ingestant substances shared some similarities. For the individuals who selected drowning as a method of suicide, medical and psychiatric problems were evident. In particular, these individuals were in poor health and were users of medical services. Indeed, physical illness was identified as a motive for the suicidal action. Anxiety and depression were experienced by these individuals and assistance was sought from medical practitioners. However, these individuals also wanted to punish others by their actions, although there were not any particularly stressful events that precipitated the suicide. Although their actions were extrapunitive, they were not particularly angry leading up to death. Therefore, the extrapunitive motivation, in the absence of angry feelings or specified interpersonal conflict, would indicate that, in general, intimate relationships were poor and contributed to the decision to suicide.

It is interesting that an extrapunitive influence was also evident in this group. It has been postulated that, when physically ill individuals experience personal criticism, even minor criticism, by those providing social support, they view themselves as being a burden, and there is a resultant increase in suicidal ideation (Brown & Vinokur, 2003). It could also be argued that this process creates feelings of ill-will in the suicidal individual, meaning that the person will use their suicidal

behavior as a means of punishing the significant other for the criticism or perceived withdrawal of support.

Medications

Individuals who chose to ingest an overdose of medication shared the medical and extrapunitive characteristics of those who chose drowning. In addition, they were anxious like the individuals who chose drowning but who were not depressed. These individuals had health problems resulting in the use of medical services. Physical illness was a contributing factor to their suicides. Punishing others was a risk factor for overdosing. No particularly stressful life event triggered the suicidal behavior. Ongoing anxiety was a problem that resulted in the use of psychiatric services. There was little evidence of anger leading up to death despite the extrapunitive motivation, and there was little evidence of interpersonal conflict as a motive for suicide. Again, it would be more likely that the suicidal behavior was a function of the poor quality of interpersonal relationships rather than a reaction to a specific interpersonal event. Stated intention to suicide was not strongly related to this method.

Discussion

It has been proposed that motivations for attempted suicide may be divided into two broad categories: internal perturbation and extrapunitive/manipulative (e.g., Holden & Kroner, 2003). It would appear from this examination of completed suicide that the extrapunitive/manipulative group of motivations do not fit well together. For example, it is evident that people who take an overdose may do so for extrapunitive reasons, but they are not particularly angry and have not experienced a specific interpersonal conflict as a trigger. Extrapunitive motives may relate to a wish to make the person suffer for a perceived injustice. Angry feelings seem to relate to outrage at the actions of another without the desire to punish, and interpersonal conflict precipitates feelings associated with an inability or lack of desire to cope without the relationship or the partner. These three factors seem to be related separately to different methods of suicide.

The medical and extrapunitive factors associated with drowning and overdosing were also present for the selection of self-poisoning with non-ingestant substances as a method of suicide. No other factors were associated with this method. The effect of perceived support withdrawal in a physically unwell individual (Brown &Vinokur, 2003) is probably most evident for those ingesting

poison, without the confounding effect of extraneous variables influencing the decision to suicide by this method.

Finally, the other or miscellaneous group of methods were made up of low frequency and often bizarre methods of suicide. These individuals had a history of psychiatric disturbance and were users of mental health services. Their psychiatric disturbance was the trigger for the suicidal action and resulted in erratic behavior leading up to death. Psychotic and psychotic-like symptoms were experienced by these individuals and the intensity of these symptoms probably increased in the time leading up to death. There was a history of previous suicide attempts that were a reflection of their ongoing psychiatric concerns. There was little evidence of an extrapunitive motivation for suicide and little evidence of interpersonal conflict or overt expression of suicidal intentions.

Although there was some evidence of an exacerbation of symptoms in the time leading up to death, there appeared to be no other factor, such as a stressful life event or an interpersonal conflict that triggered the suicidal action. Stressful life events and social factors have been demonstrated by others to have little impact on the suicides of people with serious mental illness (Cooper, et al. 2002, King, et al. 2001). This is important information in relation to the evaluation of risk of suicide among individuals experiencing psychotic symptoms.

In a similar approach, Hunt, et al. (2010) looked at methods for suicide used by *psychiatric patients* in England which limits the generalizations that can be made from the study. Hunt, et al. found that suicides by hanging were more often characterized by being male, being younger, having affective disorder, and having a short illness history. Suicide by self-poisoning were more often older, female, and had a background characterized by complex social and clinical morbidity, including high rates of alcohol and drug dependence, and personality disorder. Suicide by carbon monoxide poisoning were more often male, were older, had affective or personality disorder, and had a short illness history. Younger patients were more likely to die by jumping, as were those from an ethnic minority and those with schizophrenia. Suicides by drowning were characterized by being older and female. They were also more likely to be an inpatient and have a diagnosis of schizophrenia. However, Hunt, et al. did find age and sex to be associated with the methods chosen by their sample of suicide as well as the psychiatric diagnosis.

Can These Types Be Linked To Personal Characteristics?

It is important to ask whether these types can be linked to personal characteristics. Lester, et al. compared those using these different methods for suicide on several personal characteristics.

Those using firearms and gas inhalation (which typically means car exhaust after domestic gas was detoxified by switching from coal gas to natural gas [see Lester, 2009]) were predominantly male (>90%) while females used medications more often, and those employed and those with blood alcohol detected also preferred firearms and gas inhalation.

Those who were single preferred the violent methods for suicide as did those who were separated/divorced, while the widowed preferred drowning and poisoning. The use of violent methods was also associated with the psychological mood of distressed, agitation and feeling lonely.

It has frequently been noted that psychiatric patients who die by suicide in the hospital, while absent without permission and after discharge often use hanging, drowning and jumping, since these methods are readily available to psychiatric patients. These methods for suicide are, therefore, associated with psychiatric disorder.

Conclusion

It appears that a reasonable typology of suicides could be based on the methods chosen for the suicide.

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Suicide Studies, 2026, 7(6), 136-232

A REVIEW OF RESEARCH ON SUICIDE IN 2010

David Lester
Stockton University

From 1897 (the date of the publication of Durkheim's book on suicide) until 1997, I read every article in English on suicidal behavior. I had many boxes of 3x5 index cards, one for each article, chapter and book. I used every abstracting service available to locate these scholarly works. I reviewed the research in four books called *Why People Kill Themselves*, published by Charles Thomas.

At that point, the volume of scholarly work on suicidal behavior was too great. Locating and reviewing the articles was taking up too much of my time (I did have a full-time teaching job as a professor: four courses a semester), and so I stopped. One hundred years seemed like a great achievement.

No-one took up this task. Of course, reviews of selected topics appeared, but no comprehensive review. I am now retired, and hence this is an attempt to do a reasonably thorough review, although it will not be comprehensive. I do not have access to all the abstracting services that existed in the 20th century. Furthermore, articles in the predatory journals (those that developed to help scholars publish their work for a fee) are not typically included in the abstracting services. Therefore, many, possibly important, ideas are difficult to locate.

My goal is to see whether there have been important research and theoretical findings in the more recent literature. I have not included reviews of the literature in this essay but, of course, those reviews of the literature on specific topics may be valuable to researchers. I omit qualitative studies and physiological studies.

My interest is SUICIDE, not suicidal ideation or attempted suicide. Studies on these topics throw no light on suicide unless the researchers assess suicidal intent (or the lethality of the suicide attempt). Research on these topics is mentioned under the heading of NO USE and, in case researchers are offended by this, much of my research is included in that section.

The reviews of scholarly research published for 1998-2009 are:

Lester, D. (2024a). A review of research on suicide in 1998. Suicide Studies, 5(2), 2-61.

Lester, D. (2024b). A review of research on suicide in 1999. Suicide Studies, 5(3), 2-63.
Lester, D. (2024c). A review of research on suicide in 2000. Suicide Studies, 5(4), 54-109.
Lester, D. (2024d). A review of research on suicide in 2001. Suicide Studies, 5(4), 142-205.
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Lester, D. (2024f). A review of research on suicide in 2003. Suicide Studies, 5(6), 108-179.
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Lester, D. (2025a). A review of research on suicide in 2005. Suicide Studies, 6(2), 135-213.
Lester, D. (2025b). A review of research on suicide in 2006. Suicide Studies, 6(5), 87-176.
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Lester, D. (2026a). A review of research on suicide in 2008. Suicide Studies, 7(3), 32-118.
Lester, D. (2026b).A review of research on suicide in 2009. Suicide Studies, 7(4), 44-138

This is the review for 2010. To indicate where I searched, here is a list of abstracting services used.

Source	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Sociological Abstr.	93	106	55	56	67	62	64	107	117	107
PsycINFO	401	460	388	425	441	510	541	592	726	784

Source	2008	2009	2010
Sociological Abstr.	201	123	180
PsycINFO	984	788	858

RESEARCH OF USE FOR UDERSTANDING COMPLETED SUICIDE

Studies of Suicide Rates and Suicidality

Methodological Issues

Claassen, et al. (2010b) discussed the issues surrounding official suicide rates and ways to make them more accurate.

Rockett, et al. (2010) looked at national American causes of death labeled suicide and undetermined. They found that misclassification of suicides was worse for Blacks and Hispanics and varied with age, the presence of a psychiatric history and method of suicide.

Lester and Fleck (2010) presented students and experts on suicide a list of behaviors and asked them they would classify the behavior as suicide. There was a high level of agreement, and only significant difference was that students judged a dog who refused to eat after the death of owner more often to be a suicide (whereas

the experts *tended* more often to view a human who has an incurable illness and stops eating and drinking to be a suicide). Both experts and lay people apparently used a prototypical approach (the extent of resemblance to the prototypical suicide) rather than a feature comparison approach (defining features are necessary features, essential to meaning) for defining suicide.

Williams, et al. (2010) found that the Queensland suicide rate, based on Queensland Suicide Register data, was greater than that based on Australian Bureau of Statistics data.

Law, et al. (2010) suggested an alternative measure to years of life lost, namely, how many life years would be gained in terms of life expectancy if suicide did not occur.

Värnik, et al. (2010) noted that, after the break-up of the Soviet Union in 1989, the rate of undetermined deaths rose in the Baltic and Slavic countries, as did the rates of suicide and homicide. They argued that the undetermined deaths may have may have included homicides and accidental deaths as well as suicides.

Chang, et al. (2010b) documented that suicides in Taiwan may be undercounted by more than 30% since the demographic characteristics of suicides resemble those classified as undetermined and as accidental deaths from pesticide poisoning/suffocation.

Corcoran and Arensman (2010) documented inconsistencies and errors in the reporting of suicides in Ireland including, for example, possible misclassifications in marital status. Roughly 4.5% of all deaths differed in two reporting systems on the year of the death. Suicide rates were higher in those separated, living alone and unemployed. There was a summer peak and also on Mondays.

Regional Studies

In a samples of 17 and 20 European nations, Lester (2010c, 2010d) found that the prevalence of the brain parasite Toxoplasma gondii and the percentage of Finno-Ugrians in the populations were significantly associated with national suicide rates for both men and women.

In a sample of 38 countries, Shah (2010a) found that national data on the prevalence of smoking was associated with the suicide rates of elderly males, but

not elderly females. Controls for other socio-demographic eliminated this association but, of course, Shah did not factor analyze the variables studied to identify clusters of related variables.

In a sample of 40 countries, Shah (2010c) found that elderly female suicides rates (but not elderly male suicide rates) were associated with national rates of obesity.

In a study of 85 countries, Shah (2010b) found that there was an inverted U-shaped curve between elderly suicides rates for males and females and the Human Development Index. In a study of 85 countries, Shah (2010d) found that elderly suicide rates were associated with the proportion of the elderly, the prevalence of internet users, life expectancy, the Gini index and the GDP (Shah does not indicate *per capita*). The results varied somewhat by sex and age group (65-74 and 75+). In a sample of 85 countries, Shah (2010g) found that elderly suicide rates were positively associated with the elderly dependency ratio. In a study of 85 countries, Shah (2010h) found that elderly suicide rates and the average annual population growth were curvilinearly associated (a U-shaped curve).

In a study of 105 countries, Shah (2010f) found a curvilinear (U-shaped) relationship between elderly suicide rates and the GDP. The association between elderly mortality suicide rates and per capita health care expenditure was positive and with child mortality negative. As usual with Shah's studies, there is a preference to publish several studies rather than combining the variables into one study, and the presentation of the results is typically poor.

In a sample of 85 countries, Shah (2010e) found that general population suicide rates were associated positively with internet user prevalence, educational (literacy and school enrolment) and, for female suicide rates only GDP and negatively with the Gini index.

In a sample of 27 countries, Shah and Chandia (2010) found that general population suicide rates were negatively associated with the percentage of the Muslim population.

In a sample of 76 countries, Shah, et al. (2010) found that general population suicide rates were positively associated with the provision of mental health services (e.g., number of psychiatric beds), the percentage of the total health budget spent on mental health, and the presence of mental health legislation.

Lester (2010a) used a regression equation to predict suicide rates in 16 countries to see if the equation could predict the suicide rate in Ireland. The predictors were blood type composition, alcohol consumption, percentage of the elderly, and divorce and birth rates. The equation was good at this task, indicating that these predictor variables were useful for predicting the Irish suicide rate.

For 26 European countries, Yur`yev, et al. (2010) found that elderly suicide rates were negatively associated with positive attitudes toward the elderly (perception of the elderly as having higher status, recognition of their economic contribution and higher moral standards, and friendly feelings towards and admiration of them), where the elderly live their families more often and exit age from the labor market.

For 25 industrialized countries, Gaygisiz (2010) found that suicide rates were not associated with GDP per capita or life satisfaction. The male/female suicide rate ratio, but not life satisfaction, was negatively associated the GDP per capita.

In a sample of countries with data for 71-94 countries, Minkov (2010) found that suicide rates were positively associated with IQ, negatively with importance of religion and perception of physical health, but not with gross national income per capita.

In a study design that makes no sense, for 48 countries and 50 American states combined, Large, et al. (2010) found that rates of infant homicide were positively associated with homicide rates and suicide rates, but rates of homicide and suicide were not associated. For the American states alone, the same results were obtained, and for the 48 countries alone the same results were obtained.

Regions within a Country

In a study of the American states, McCann (2010) found that suicides rates were predicted by estimates of low neuroticism and low agreeableness (from the Big 5 personality traits: OCEAN) after controls for demographics and estimates of depression.

Lanier (2010) studied 505 American counties with at least 100 Native Americans or at least1% Native Americans. The Native American suicide+homicide rate was associated positively with an economic index, the percentages of female-headed households, divorced and those aged 15-29, and

negatively with the Gini index, rural, racial heterogeneity and the percentage of those with some college education. Lanier also looked at the suicide/homicide ratio, but not each behavior separately.

In 1,867 municipalities and wards and over a five-year time period in Japan, Kuroki (2010) found that male suicide rates were associated with unemployment rates but not with per capita income. Female suicide rates were associated with unemployment rates and per capita income. Kuroki, as well as confusing ecological and time series data, also presented the results for using log suicide rates and suicide rates by age. Kuroki concluded that, "The results show that unemployment is significantly associated with male suicide rates, especially those of prime age working men, while the results are not straightforward for female suicide rates" (p. 683).

At the county level for the United States, Baller, et al. (2010) explored the impact of the bank suspension rate in 1930 and many other variables with the suicide rate in 2000. For counties in the American west, there was no association (perhaps because bank suspensions were relatively rare in the west) but, for non-western counties (n=2,642), the association was positive, even after controls for other variables. Many other variables were associated with the suicide rates such as the percentage of elderly in 2000 (positively) and percentage of families with radios in 1930 (negatively).

In a study of 1,451 American rural (nonmetropolitan) counties, Cutlip, et al. (2010) found that white suicide rates were positively associated with the proportion of the county that was urban and negatively with independent middle class, stability, population, and civic engagement (e.g., voting and civic and social organizations).

In a study of 290 municipalities in Sweden, Magnusson and Mäkinen (2010) found that male suicide rates were predicted by low education and alcohol consumption. Female suicide rates were predicted by alcohol consumption and divorce rates and *negatively* by income and unemployment.

For 99 districts in Austria, Kapusta, et al. (2010a) failed to provide correlations or regressions for predicting suicide rates. However, they say:

Only the number of psychotherapists per 10,000 population had a significant effect on suicide rates …..; however, after adjustment for socioeconomic factors (in particular urbanicity as indicated by population density, average income, and

proportion of non-Catholics), the observed effects were no longer significant. In the final model, only the socioeconomic component remained significant. (p. 1198)

Over the Swiss cantons, Ajdacic-Gross, et al. (2010) found that proportion of households owning firearms was associated with the proportion of suicides using firearms by men and by women.

For 85 French *départments* in 1825-1830, Whitt (2010) found that suicide rates were positively associated with modernization and urbanization and negatively with resistance to internal colonialism and distance from Paris.

In 19 cities/counties in Taiwan, Tsai (2010a) found that suicide rates were positively associated with a higher percentages of elderly, those living alone, unemployed and poor, and positively with rain and negatively with atmospheric pressure. The results differed slightly for male and female suicide rates.

Over the 23 cities/counties in Taiwan, Tsai (2010b) found that male and female suicide rates were inversely associated with the regional density of newspapers but not with the density of televisions. The density of in-home personal computers was positively associated with the male suicide rate but not with the female suicide rate.

In a study of 78 Russian regions, Kaylen and Pridemore (2010) found that a measure of societal heavy drinking (age-adjusted death rate from alcohol poisoning), single parent households and regions in the east were associated with male and female suicides of those aged 10-19 using multiple regressions, and for males negatively with educational level.

In a study of 16 Italian regions in 1911, Felice (2010) found that suicide rates were associated with per capita GDP, education and latitude.

Lester (2010e) found no association between suicide rates and marriage, birth, mortality, or infant mortality rates over the nine regions of Scotland.

Time-Series Studies

In Switzerland for the period 1969-2005, Hepp, et al. (2010) found that the variation over time differed by the method used for suicide, often impacted by societal changes such as the introduction of catalytic converters on cars and physician assisted suicide.

In Denmark for 1970-2006, Andres and Halicioglu (2010) found that a rise in real per capita income and fertility rate and a fall in unemployment decreased the suicide rates for males and females. Divorce was positively associated with suicide rates. However, rather than using simple time-series regressions, they used a method that is incomprehensible to non-statisticians.

In Turkey for the period 1974-2007, Alptekin, et al. (2010) found that the unemployment rate and suicide rate were associated using a *var* analysis.

Chen, et al. (2010a) studied Hong Kong and Taiwan for the period 1997-2007, where 2003 was a turning point in unemployment rates from high rates to low rates. Suicide rates rose in both countries from 1997 to 2003, after which, with lower unemployment rates, suicide rates declined in Hong Kong but continued to rise in Taiwan, trends most notable for male suicide rates. Chen, et al. attributed the deviant findings in Taiwan to an increase in the use of charcoal burning as a method for suicide.

From 1995 to 2006 in Taiwan, Pan, et al. (2010) found that male and female suicide rates rose, as did the male/female rate ratio. The suicide rate using charcoal rose steeply, and those using charcoal were more often men and single or divorced.

Chen, et al. (2010d) found the suicide rate in Taiwan for 1978-2006 was positively associated with the unemployment rate, strongest for men and both men and women aged 25-64. In Taiwan for 1959-2007, Chang, et al. (2010c) found that unemployment rates were positively associated with male suicide rates and less strongly with female suicide rates.

For 12 industrialized countries, Lester and Braaten (2010) found that suicide and homicide rates were not associated with the per capita use of DDT.

For four Nordic countries (Denmark, Finland, Norway and Sweden) for the period 1990-2006, Zahl, et al. (2010) found no association between suicide rates and sales of SSRIs or tricyclic antidepressants.

In a time-series analysis for 1980-2006 for the European Union (as a whole?), Innamorati, et al. (2010a) found that the suicide rate of those aged 15-29 was associated positively with the homicide and assault rate in those aged 15-29, the unemployment rate for those aged 15-29, alcohol consumption and road accidents involving alcohol and negatively with the literacy rate. The authors noted

that the results might have differed for former EU countries and newly admitted EU countries.

In a study of temporal trends in age-adjusted suicide rates for people aged 65+ residing in the EU from 1980 to 2006, Innamorati, et al. (2010b) found that the elderly suicide rate was positively associated with available beds per capita and negatively with public health expenditures on health for female suicide rates and public health expenditures on health for male suicide rates. Unemployment did not predict elderly suicide rates. The suicide rate time trends differed for old and new members of the EU, but the regressions did not include this variable.

In one province in China (Shandong Province) from 1982-2005, Zhang, et al. (2010d) found that the suicide rate was negatively associated with income and GDP per capita.

Over time (1951-2005) in the United States, Wu and Cheng (2010) found that suicide rates exhibited the pattern of an asymmetric cycle, significant for men and working-age groups. They concluded that the suicide rate is countercyclical. What this meant is that the number of suicide rate does not rise significantly during a downturn but falls significantly during an upturn.

Although not using a time-series analysis, Booth (2010) hypothesized that a rising suicide rate in Guam was the result of direct and indirect suicide contagion following the death by suicide of a respected politician, which seems to have strongly influencing period and cohort patterns. Suicide pacts inflated suicide rates among young people.

Research on Distal Variables

Marital Status

In Northern Ireland, Corcoran and Nagar (2010) found that married people had lower suicide rates, significant only for men (who, of course, constituted 80% of the suicides).

Masocco, et al. (2010) found that suicide rates by sex and marital status varied absolutely and relatively over the different regions of Italy.

Method

Kastanaki, et al. (2010a, 2010b) reported on suicides by firearms and by pesticides in Crete (Greece). Firearms were used more by men less than 55 years of age, living in the western part of the island, with some degree of planning prior to the suicidal act, and using a shotgun, but less likely leaving a suicide note. Those using pesticides were primarily middle-aged males, rural habitants, who carried out a suicidal act by consuming methomyl or paraquat and found dead in the place of intoxication.

Johnson, et al. (2010a) studied the source of firearms used by adolescent suicides in the United States. The majority (81%) took place in the adolescent's home using firearms owned by the parents. Only 18% of the firearms were owned by the adolescent.

Tait and Carpenter (2010) in Queensland (Australia) found that a 1996 gun control law was followed by a decrease in the firearm suicide rate, as well as a decrease in the total suicide rate, indicating that no substitution of method was observed. (They do not report suicides by methods other than guns.) Firearms for suicide were more common in men, especially older (<75) men, those in rural areas and those with no psychiatric disorder, and less often by those with prior attempted suicide. Aborigines more often used hanging for suicide.

In a study of train suicides in the Netherlands, van Houwelingen, et al. (2010) found that:

1. The incidence of train suicides is unrelated to railway parameters [e.g., the number of trains per day] .
2. Being familiar with railway transportation as a passenger is not a contributory factor.
3. Train suicide rates are unrelated to regional population density.
4. The incidence of train suicides parallels that of general population suicides.
5. Half of the train suicides took place at a limited number of locations, the most important of which were situated within a village or town and were close to a psychiatric hospital. (p. 281)

Lubin, et al. (2010) found that restricting Israeli military personnel from taking firearms home when on leave resulted in a decrease in the suicide rate of adolescents (by 40%). This decrease was a result of a decrease in suicides using firearms on weekends.

Sinyor and Levitt (2010) documented that erecting a barrier at the Bloor Street Viaduct in Toronto (Canada) reduced the number of suicides from the bridge but did not change the suicide rate by jumping overall in Toronto, suggesting that potential suicides changed from where they jumped.

Sarma and Kola (2010a, 2010b) compared suicides in Northern Ireland using firearms with those using other methods. The firearm suicides were more often male, rural, agriculture employed and younger, but did not differ in marital status.

Yip, et al. (2010c) found that removing charcoal from shops in one region of Hong Kong (compared to a control region) reduced the suicide rate using charcoal without an increase in the suicide rate using other methods.

Climate

In a study of suicides in cities in South Korea, Kim, et al. (2010a) found that suicide rates were positively associated with particulate matter ≤10 μm (average of 0 to 2 days prior to the day of suicide) and particulate matter ≤2.5 μm (1 day prior to the day of suicide) respectively. The results were impacted by sex, age, season, socioeconomic status and medical diseases (such as cardiovascular disease), but the data on this were poorly presented.

In Bosnia-Herzegovina, Kordić, et al. (2010) found that the days on which individuals attempted or complete suicide had lower atmospheric pressure than the average for the month, but did not differ in temperature.

Season and Timing

In America, Kposowa and D'Auria (2010) found that suicides were more common Wednesdays (and less on Sundays) and in the summer (and less in winter) and were associated with many state variables. However, they did not carry out a proper ecological study of the variables.

In Hungary, Döme, et al. (2010) found that suicides were more often born in spring and summer than expected, especially in July. This effect was stronger for males and for those using violent methods.

In Hungary 1998-2006, Sebestyen, et al. (2010) found that, as the prescriptions of anti-depressants increased, the seasonality of male suicide

declined. They did not control for other socio-demographic changes over this period.

In England and Wales, Salib and Cortina-Borja (2010) found that suicides were more often born in the spring (April to June, with a peak in May) than other seasons for both men and women. This was found for all methods except burning which was rare but peaked in the winter.

In one region of Germany, Mergl, et al. (2010) found that female *suicide attempters* had a trough in the spring, especially for low risk attempters (use of a non-violent method) but not for men. This contrasts with a frequently reported peak in the spring for completed suicides.

Postolache, et al. (2010) found a spring peak in suicides in Denmark for both males and females and with and without mood disorders.

Presidential Elections

Classen and Dunn (2010) studied yearly suicide rates in American election years for the period 1981 to 2005 for the states. (They did not have monthly suicide rates by state.) The suicide rate for males and for females aged 20–59 years old fell in states that went for the losing candidate relative to states that went for the victor.

Disasters

Claassen, et al. (2010a) found that suicide rates in the New York City metropolitan areas dropped in the 180 days after the 9/11 attack, but not in regions outside that area and not as a result of the Pentagon attack and the Flight 93 crash site.

Media Reports

In Austria, Niederkrotenthaler, et al. (2010) found that repetitive reporting of the same suicide (especially by jumping) and the reporting of suicide myths were positively associated with an increase in suicide rates in the following week, whereas coverage of individual suicidal ideation was negatively associated with suicide rates. In addition, “the mastery of crisis class (articles on individuals who adopted coping strategies other than suicidal behavior in adverse circumstances)

was negatively associated with suicide, whereas the expert opinion class and the epidemiological facts class were positively associated with suicide." (p. 234)

After the suicide of a famous singer in Taiwan, Chen, et al. (2010e) interviewed *attempted* suicides in the four weeks after her suicide and found that 37% reported being influenced by the suicide, especially men and the younger (<30) attempters, as well as by the method that she used (charcoal burning). Those influenced were less often depressed but more often frustrated in love.

Occupation

Violanti (2010) found that police officer deaths were likely to be classified by coroners as *undetermined* than were deaths of firefighters and military personnel, especially for females and African Americans. This suggests misclassification of suicides for police officers.

In Austria, Kapusta, et al. (2010b) found that the suicide rate in male police officers was similar to men in the general population, but the female suicide rate for female police officers was much lower than females in the general population. The male suicides used methods similar to those used by male suicides in general.

Barron (2010) described the modal police officer suicide in New South Wales (Australia):

- male, about 35 years of age, married or in a de facto relationship, Catholic, holding Higher School Certificate or equivalent, residing at home with spouse and children, and a smoker;
- on a Tuesday, at home, usually in the main bedroom, will be a moderate to heavy drinker (of alcohol), will be affected at time of decision to suicide, have access and use to firearm (usually service firearm), will have communicated suicide intent to a work colleague;
- will be either currently under investigation for a work related incident or under review for a performance/adjustment issue:
- some recent history of mental illness (usually depression or anxiety related), taking medication. (p. 378-379)

In Queensland (Australia), Andersen, et al. (2010) found a higher rate of suicide for males in the agricultural, transport and construction occupations and, for females, nurses, artists, agricultural workers and cleaners. Education professionals (of both genders) appeared to be at lower risk.

For Canada, Mustard, et al. (2010) found that suicide rates varied by occupation, especially for semi-skilled and unskilled occupations and *no occupation* for both men and women. The suicide rates by specific occupation were in e-tables and not downloaded with the article.

In New Zealand, Skegg, et al. (2010) found that suicide rates were higher in male and female nurses, male hunters and female pharmacists and lower in the police and military personnel. Nurses, doctors and pharmacists were more likely to use poisoning while farmers and hunters were more likely to use firearms.

Roberts, et al. (2010a) found that British seafarers had higher suicide rates than the general population, although the rates had dropped in recent years. Suicide rates were higher for all ranks below officers, Asian seafarers and older seafarers and were lower than those in Asian and Scandinavian merchant fleets.

Life Insurance

Typically life insurance policies do not pay out after a suicide for the first one or two years after the policy is purchased. Yip, et al. (2010a) documented fewer suicides (and no increase in accidental deaths) in the exclusion period for Australian life insurance data. More suicides were detected for the first two years after the exclusion period, and higher insured sums were associated with higher rates of suicide.

Urban Rural Differences

In South Korea, Kim, et al. (2010b) found that, after controlling for age, those with less education had higher rates of suicide as did those in rural areas and deprived districts. Rates of attempted suicide were also higher in rural areas.

For Ireland, Corcoran, et al. (2010) found that urban regions had higher rates of elderly attempted suicide and suicide while cities also had higher rates of elderly attempted suicide.

Race and Ethnicity

In Singapore, Chia, et al. (2010) found that suicide rates were higher in Chinese and Indians and lower in Malays. Suicide rates were highest overall in elderly males.

Visitors versus Residents

Shrira and Christenfeld (2010) compared suicide rates of visitors and residents in American states with high suicide rates and low suicide rates. In states with a high suicide rate, they found that the *suicide proportionate mortality ratio* (PMR) was highest in visitors to the states followed by residents at home. In states with a low suicide rate, the suicide PMR was highest in visitors to the states, followed by residents away from home. The results for firearm suicides were slightly different from those trends.

In the USA from 2004-2009, McCarthy (2010) found that internet searches for suicide were negatively associated with general population suicide rates but positive for youths aged 15-25. Searches for suicide were positively associated with searches for depression and declined from July-September

Era

Weaver and Monroe (2010) compared suicides in New Zealand in the 1930s and 1980s and found large differences, concluding that: "the so-called 'eternal' motivations to suicide – including physical suffering, financial distress, mental illness, romantic disappointment and social disgrace – are mediated through the social milieu of the time" (p. 100).

Discussion

Research reviewed here tapped two rarely studied variables: the month of birth of suicides and the era.

Studies of Suicides

Methodology

An, et al. (2010b) had attempted suicides and community controls (target subjects) fill out impulsivity and aggression inventories and also had their relatives fill out the inventories for the target subjects. They found good agreement, thereby validating the use of informants in psychological autopsy studies.

Theories and Typologies of Suicide

Pridmore and Admadi (2010; Pridmore & McArthur 2010) described three types of suicides:

1. Predicament 1 is when a mental disorder is the predicament
2. Predicament 2 is when there is no mental disorder present and environmental factors constitute the predicament.
3. Type 3 suicide is when there is no mental disorder and the predicament to which the individual is exposed is very clear to the observer.

The predicaments can be divided into those for which their involvement in the suicides in very clear versus less clear.

Van Orden, et al. (2010) provided a review of research on Joiner's Interpersonal Theory of Suicide which I and others have argued is not a theory but one type in a future typology. Van Orden, et al. are broadening the theory in an effort to make it a theory.

Suicide Notes

Leenaars, et al. (2010a) compared suicide notes from the USA and Turkey. Of Leenaars's eight content categories, only one differentiated the notes. The Turkish suicide notes had more indirect expressions (veiled communications). Leenaars, et al. (2010b) compared American and Indian suicide notes and found that the Indian notes more often had indirect expression including veiled aggression or aggression turned inward, and also unconscious dynamics. Leenaars, et al. (2010c) compared the last letters of self-immolation suicides by martyrs in South Korea with American suicide notes. The martyr's notes scored higher for all eight of Leenaar's content categories.

Lester (2010b) analyzed a journal, two suicide notes and two tape recordings made by a young adult suicide, and found a calming trend from the journal entries to the suicide notes to the tape recordings, with an additional increase in positive emotions expressed from the first recorded message to the second recording made just an hour or two before his death.

Lester, et al. (2010) examined a large sample (n=261) of suicide notes from Tasmania (Australia). The notes from women differed in 13 ways: they had a higher percentage of words found in the dictionary, pronouns; "I", "we",

references to the self, negations, positive feelings, references to cognitive processes, insight words, discrepancy words such as should, would, and could, and present tense verbs, and a lower percentage of articles such as a, an, and the, and numbers. Twenty four differences were found by age and seven by method of suicide.

Youth Suicides

Renaud, et al. (2010) compared child and adolescent suicides with community controls and found no differences in same-sex sexual orientation nor intimidation related to same-sex sexual orientation. Among the suicides, those with same-sex sexual orientation were more likely to have anxiety disorders.

Adult Suicides

In a 40-year follow-up of middle-aged men from four European countries, Giltay, et al. (2010) found that forced vital capacity (maximal volume of air that can be forcefully expelled from the lungs after maximal inhalation) and height were negatively associated with suicide (as well as older age, being unmarried and of lower social class).

Yeh and Lester (2010) found that suicides from the Golden Gate Bridge in 1999-2009 were younger than other suicides handled by the Marin County Coroner but did not differ by sex or race. Those witnessed did not differ from those not witnessed. Compared to suicides from the bridge in the 1970s, recent suicides were older, more often male, and more often nonwhite.

In a small sample of psychiatric inpatient suicides, Neuner, et al. (2010) found no association with season, month or weekday or with month of birth. There was a tendency for more to take place around public holidays.

In a sample of suicide by jumping in China, Mao and Lester (2010) found no differences in the heights from which men and women jumped.

Rojas and Stenberg (2010) followed up a cohort of men in Sweden born in 1953 for 30 years. They found that self-rated loneliness at age 12–13, school absenteeism at the same age and growing up in a family which received means-tested social assistance at least once during the period 1953–1965 predicted suicide between 1970 and 1984.

Pederson and Fiske (2010) reviewed twin studies and concluded that there was evidence for a genetic role in suicide, attempted suicide and suicidal ideation, even when accounting for the effects of psychopathology.

In Norway, Gravseth, et al. (2010) followed up those born in 1967-1976 until 2004. Suicide was more common in those not being firstborn, instability of maternal marital status during childhood, parental suicide, low body mass index (for men), low education and indications of severe mental illness.

In Japan, Takai, et al. (2010) found that those who attempted hara-kiri suicide were likely to be male, older, be diagnosed with schizophrenia, survive, and be married.

In Hong Kong, Wong, et al. (2010) compared suicides with and without gambling problems and living controls but failed to report meaning statistical comparisons between the two types of suicides.

In one region of India, Manoranjitham, et al. (2010) compared suicides with living controls. The suicides more often had a psychiatric disorder, ongoing stress and chronic pain.

In a national sample in China, Tong and Phillips (2010) found that the suicide rate in those with mood disorders was highest, followed by that for anxiety disorders, psychotic disorders, substance use disorders and organic mental disorders. The suicide rate among urban residents with any mental disorder was more than double that of rural residents.

Brådvik and Berglund (2010) compared depressed suicides with depressed inpatient controls and found that, in the early episodes of depression, there were a similar number of suicide attempts in both groups. In the later episodes, the future suicides showed more suicide attempts compared to controls, but only for those with unipolar depression.

In the Swedish population born in 1946-1968, von Borczyskowski, et al. (2010) found that suicide was predicted by parental psychotic or affective disorder for both men and women, but more strongly for women, as well as low parental socioeconomic status for men and living in a metropolitan area for women.

In one American city, Tewksbury, et al. (2010) compared men who used firearms versus hanging, but did not present good data, so that one has to guess the

direction of the differences. The firearm suicides were younger, more often had drugs present in the body, more often had alcohol present and differed in weight (body mass index). Only age, not using a firearm and being married predicted whether the suicides left a suicide note, perhaps.

In a national sample of Americans followed up for 16 years, Denney (2010) found that suicide was less common in women, those married, those with children and those living with family members. Less education, nor working, lower income and worse health increased the risk of suicide.

In England, Windfuhr, et al. (2010) compared those who died by suicide in a region away from where they lived with resident suicides. The non-resident suicides were younger and more often with social adversity and severe mental illness. They were more likely to be ruled as open verdicts and used different methods (e.g., less by hanging) and often chose hotspots for suicide.

Haines, et al. (2010) compared suicides in Australia using different methods for suicide. Those using gas inhalation were reacting to interpersonal conflict or loss and misused alcohol. Those using jumping had ongoing psychiatric problems and a history of suicidal behavior. Those using firearms were characterized by anger and were more likely to commit murder-suicide. The groups also differed in sex, marital status, employment status, use of medications, drug and alcohol, previous suicidal history, psychiatric and psychological symptoms, psychological state prior to the suicide and the reasons for their suicide.

In Slovenia, Rodi, et al. (2010) found that suicides were more likely to have visited their primary care physician in the month prior to their suicide than did other primary care patients.

Zhang (2010) compared rural female suicides aged 15-35 with living controls using informants. The suicides did not differ in being married or single or in fertility. The suicides had worse education, a lower level of personal and family annual income, less often Party or League membership, more often a belief in religion or superstition, worse physical health and a higher mental illness prevalence, and less social support.

Zhang, et al. (2010b) compared young (aged 15-34) rural Chinese suicides with living controls. The suicides more often had a psychiatric disorder, especially the male suicides as well as having a lower education level, being not currently

married, having a lower level of social support, and having a history of recent and long-term life events.

In rural China, Zhang, et al. (2010c) compared suicides aged 15-34 with community controls using informants for both groups. The suicides more often had a mental disorder, more often were religious, and were more impulsive. Psychological strain, resulting from conflicting social values between communist gender equalitarianism and Confucian gender discrimination, was more common in the female suicides. Marriage was a protective factor for the men but not for the women.

Kong and Zhang (2010) compared rural suicides aged 15-34 with unmatched living controls using informants. Pesticide access (especially insecticides) was more common for the suicides even after controlling for social and psychiatric domains (education level, living situation, marital status, family annual income and mental disorder).

Tseng, et al. (2010) studied patients released from inpatient psychiatric care. Those who died by suicide in the next year more often had schizophrenia, a shorter disease direction and comorbidity with cancer. Those dying by suicide within one week of discharge differed from the other suicides – they had a shorter disease duration and were more often male, single, with schizophrenia, cancer and substance abuse.

In an Australian sample of mental health patients, Sankaranarayanan, et al. (2010) found higher suicide rates in rural regions, and the rural suicides used different methods than the urban suicides.

In a study of first-degree relatives of suicides, McGirr, et al. (2010) found that:

Despite normal diurnal variation, relatives of suicide completers exhibited blunted cortisol and a-amylase TSST [Trier Social Stress Test] reactivity. Although there were no baseline differences in conceptual reasoning, sustained attention or executive function, the relatives of suicide completers did not improve on measures of inhibition upon repeated testing after TSST. Secondary analyses suggested that these effects were related to suicide vulnerability independent of major depression. (p. 399)

In a sample of attempted suicides followed for 21-31 years, Runeson, et al. (2010) found that individuals who had attempted suicide by hanging, strangulation, or suffocation were more likely to die by suicide, followed by those using gassing, jumping from a height, using a firearm or explosive and drowning, with those using cutting or poisoning having the lowest risk of suicide. A psychiatric disorder also increased the rate of suicide. The majority who died by suicide used the same method as that for their earlier attempt.

In a poorly designed and reported study of suicides in Sweden compared to people in the general population, Reutfors, et al. (2010) reported that the:

highest suicide risk during hospitalization and in the year following discharge was found for mood disorder with the risk peaking in the first week following discharge Compared to that for mood disorder, the suicide risk for schizophrenia spectrum disorder and alcohol use disorder was about half and more constant over time. (p. 741: edited)

In a study of attempted suicides and healthy controls, Jokinen, et al. (2010a) found that patients who died by suicide within four years had significantly higher scores in exposure to violence as a child, expressed violent behavior as an adult, and the Karolinska Interpersonal Violence Scale (KIVS) total score compared to survivors. Attempted suicides scored significantly higher compared to healthy volunteers in three of the four KIVS subscales.

Burrows, et al. (2010) compared Canadian suicides with attempted suicides discharged from hospitals and found that the rates of both were higher in the more deprived regions of Québec but this differential differed in size by age and sex.

In a sample of attempted suicides, Misson, et al. (2010) found that a factor analysis of the suicide intent scale identified four factors (conception, preparation, precautions and communication), while the risk-rescue rating scale had three factors (medical damage, implementation and rescue conditions). The researchers found that serious suicide attempts were characterized by less communication and more precautions against discovery, whereas violent attempts were associated with higher risk acts. Neither violent nor serious attempts were characterized by more planning.

In one region of England, Dutta, et al. (2010) studied a sample of patients presenting for the first time with psychosis followed for 11.5 years. The suicide rate was higher than the rate in the general population and highest in the first year,

but persisted throughout the follow-up period. They also noted that the widely held view that 10% to 15% die of suicide is misleading because it refers to proportionate mortality, not lifetime risk.

Ilgen, et al. (2010b) studied American military veterans who died by suicide in a 7-year follow-up study. Suicide was predicted by a bipolar diagnosis for men and substance abuse disorder for women, although veterans with any psychiatric disorder had a higher suicide rate.

In a national sample in South Korea followed up for 7 years, Khang, et al. (2010) found that suicidal ideation at baseline was associated with a higher risk of suicide during the follow-up and, for men only, with a higher risk of death from cardiovascular disease, external causes, and "other" causes

Séguin, et al. (2010) compared suicides in Canada with gambling problems and those without such a problem. The gamblers more often had a Cluster B personality disorder, were less likely to have had contact with mental health services and had a trend toward less often having psychosis.

In a study of U.S. Army suicides versus controls, Bell, et al. (2010) found that the suicides were more often white, male, single and enlisted soldiers with a prior injury or mental health hospitalization.

In a 60-year follow-up of the people in the Lundby study, Brådvick, et al. (2010) found that suicide was predicted by depression, alcoholism and major depression with psychotic/melancholic features.

In a large sample of Finnish suicides born in 1966 as only children and followed-up for 39 years, Miller, et al. (2010a) found that, for females but not for males, increasing paternal age was associated with a linear increased risk of suicide (and all-causes mortality), Increasing maternal age was associated with a significantly decreased risk of suicide (and all-causes mortality).

In a national Danish sample, Andrés, et al. (2010) found that SES (low income, unskilled blue-collar work, non-specific wage work and unemployment) was associated more strongly with suicide for men than for women. Being married and parenthood was protective against suicide, with a stronger impact for women. Living in a large city raised suicide risk for women but reduced it for men. Males with a foreign citizenship in Denmark had a lower risk of suicide compared with Danish citizens, but only for male immigrants.

In a national study in Sweden, Wilcox, et al. (2010) found that offspring of parents who died by suicide had a higher suicide rate, but not offspring of parents who died accidentally or from other causes. This was found for those who were children and adolescents when their parents died, but not for those who were young adults. The offspring of parents who died by suicide were also at higher risk of hospitalization for suicide attempt, depressive, psychotic and personality disorders, and hospitalization for drug disorders and psychosis. All offspring of parents who died by any cause had higher rates of violent criminal convictions.

In Taiwan,Yang (2010) followed up for 20-29 years a national sample of women who had after their first live birth. The suicide rate was less for women who gave birth after the age of 25, had more than one child, were married, had more years of school and gave birth in a hospital or clinic.

Lester and Hathaway (2010a) found that, in samples of organ donors, homicide victims had significantly more individuals with type O and type B than organ donors in general, while suicides did not differ. Lester and Hathaway (2010b) found that suicides were much less likely to be organ donors than those dying from murder and motor vehicle accidents.

Conwell, et al. (2010) compared elderly suicides (>50 years of age) with community controls. The suicides more often had Axis I diagnoses, including current mood and anxiety disorders, worse physical health status, and greater impairment in functional capacity in daily living.

People with Psychopathology

For patients in mental health care in the Netherlands, Huisman, et al. (2010) found that:

Psychotic disorders were associated with jumping from heights, and substance-related disorders were associated with self-poisoning. Depressive disorders were not associated with any particular suicide method. Male patients preferred hanging, female patients self-poisoning. Inpatients preferred jumping before a train, outpatients self-poisoning. Bipolar patients preferred jumping before a train over hanging. (p. 94)

Hunt, et al. (2010a) looked at methods for suicide used by psychiatric patients in England. Current inpatients were more likely to use hanging, jumping

and drowning and less likely to use self-poisoning and carbon monoxide than outpatients. The patients using the different methods differed on many demographic and clinical variables.

Hunt, et al. (2010b) studied psychiatric inpatients who died by suicide after absconding from the ward. Compared to other patient suicides, the absconding suicides were more often young, unemployed and homeless. Schizophrenia was the most common diagnosis, rates of previous violence and substance misuse were high, and they were more likely to have been legally detained for treatment, non-compliant with medication, and to have died in the first week of admission.

Schizophrenia

Carlborg, et al. (2010) followed up schizophrenics for 25 years and found that prior attempted suicide predicted subsequent suicide.

Reutfors, et al. (2010) followed up patients with first clinical diagnosis of schizophrenia, schizophreniform or schizoaffective disorder for five years after diagnosis. The suicides more often had a comorbid mood disorder. Differences on other variables were reported in a 2009 article!

In China, Kasckow, et al. (2010) compared schizophrenics who died by suicide versus accidents and found that the suicides were more likely to have a recent DSM IV diagnosis of major depression, depressed mood, thoughts of death and a prior suicide attempt, a higher overall depression severity score and greater dysfunction due to depressive symptoms.

Substance Use Disorders

Giupponi, et al. (2010) compared male suicides in one region of Italy with and without alcohol use disorder or substance abuse disorder and those with neither disorder. The groups differed in education and in stable versus unstable employment.

Ilgen, et al. (2010c) studied veterans with substance use disorders who died by suicide during a four-year follow-up. A diagnosis of depressive, anxiety, bipolar and posttraumatic stress disorders, schizophrenia, and personality disorders were associated with increased risk of both violent and nonviolent suicide. These associations were stronger for nonviolent than violent suicide deaths. The risk of

nonviolent suicide was greater among patients with opioid-use disorders or a clinical diagnosis of abuse or dependence on multiple substances.

Zhang, et al. (2010e) compared male suicides in China who had alcohol use disorders, those who used alcohol at the time of the suicide, and those with neither characteristic. They found that those with an alcohol use disorder were more likely to have made previous suicide attempts, and suicides with acute alcohol use were less likely to have poor overall functioning in the month before death. They were also less often married and less often agricultural laborers.

Offenders

In a 2¾-year follow-up of 138 stalkers in Australia, McEwan, et al. (2010) found three suicides, giving a suicide rate of 2,200 per 100,000 per year. (I calculate the rate as 790.)

In a study of 1,082 American state prisons, Dye (2010) found that the number of suicides (range 0-4) was higher in super-maximum and maximum security prisons (relative to minimum), under conditions of overcrowding and violence, and in prisons where a greater proportion of inmates received mental health services.

Pratt, et al. (2010a) compared English prisoners who died by suicide within a year of release with a sample of those who did not. The suicides were older, released from a local prison, with a history of alcohol misuse or self-harm, a psychiatric diagnosis, and requiring Community Mental Health Services (CMHS) follow-up after, release from prison. The suicides were less often non-white and with a history of previous imprisonment.

In a sample of American serial killers, Lester and White (2010) found that those dying by suicide did not differ in sex, race, or the motive for the killing from those who were arrested

Medical Problems

In a seven-year follow-up of American veterans, Ilgen, et al. (2010a) found that the suicide rate was higher in those with severe or very severe pain. Those reporting severe pain were more likely to be younger, male, non-white, and married; to have lower levels of education; to be a smoker; to be diagnosed with depression, PTSD, anxiety disorder, alcohol or other drug use (but less likely to

have bipolar disorder and schizophrenia or schizoaffective disorder), diabetes, complicated diabetes, COPD, and cerebrovascular disease; and to report worse physical and mental health functioning. In a multiple regression, severe pain still predicted suicide.

In Finland, Forsström, et al. (2010) found that stroke patients who died by suicide were more likely to have pre-stroke depression.

Kostić, et al. (2010) followed patients with Parkinson's disease for eight years and found a suicide rate five times higher than expected. In a second study, this time of living patients with Parkinson's disease, suicidal ideation was predicted by psychiatric symptoms (depression, anxiety and hopelessness), but not by Parkinson-related variables.

Kuo, et al. (2010) followed up high school students (aged 11-16) in Taiwan for ten years. Suicide was more common in those with asthma at baseline, but natural deaths were not more common. Having a greater number of asthma symptoms at baseline was associated with a higher risk of subsequent suicide.

In a national sample of suicides by people with cancer in Taiwan, Chung and Lin (2010) found that those who used violent methods were more likely to be male, older, unemployed, to have low monthly incomes, breast cancer, to die in their hometowns, and to have higher Charlson's index scores.

Yip, et al. (2010b) noted a rise in suicide rates in Hong Kong during the SARS epidemic. In a comparison of suicides in which SARS played a role and the other suicides, no differences were found except for more often feelings of disconnection in those in which SARS played a role.

Suicide-by-Cop

Lord and Sloop (2010) compared those who engaged in suicide-by-cop with those who self-inflicted the suicidal action (completed or attempted) during a confrontation with the police. The suicide-by-cop suicides less often had a mental disorder, less often had previously attempted suicide, more often had committed a criminal act, and used a gun.

Discussion

The only new variable studied in this section was the impact of the age of the father of the suicide

Murder-Suicide

Liem, et al. (2010) compared cases of filicide with filicide-attempted suicide. The filicide/attempted suicides were less often step-parents, were older and more often separated and killing children >6 years, less often child abusers, more often motivated by reprisal and altruism, more often premeditated, with a symbiotic relationship with the child, and more often with multiple victims.

In the Netherlands, Liem and Nieuwbeerta (2010) compared murder-suicides with homicides and suicides. Logistic regression showed that murder-suicides differed from both homicide and suicides. Compared to homicides, the murder-suicides more often had multiple victims and occurred domestically but did not differ in method used. The murder-suicide perpetrators less often used poisoning for their suicide. The murder-suicides victims were more often female, Dutch, and young.

Warren-Gordon, et al. (2010) studied murder-suicides reported in the *New York Times*. Murder-suicides usually involved a male perpetrator and an intimate partner victim who was either a wife or girlfriend, with the event occurring in a private home. A firearm was the most commonly used method for both the murder and the suicide, particularly if there was more than one murder victim.

In America, Bridges and Tankersley (2010) found that the victims of murder-suicide were older than victims of homicide, overall, for females (but not for males) and for whites (but not for blacks)

Studies of Attempted Suicides

Most of the research here assessed the suicidal intent or medical lethality of the attempted suicide.

Adults

DeJong, et al. (2010) compared attempted suicides of low and high lethality and suicides. There were linear changes in age (increasing) and gender (% males),

job stress and divorce/relationship break-up, but not for race or marital status. There were increasing linear changes in leaving a suicide note and use of drugs/alcohol prior to the suicidal act. There were no linear changes in symptoms of depression or other clinical variables except increasing fatigue (% yes).

In a sample of psychiatric inpatients to a crisis unit, Claes, et al. (2010) compared those with NSSI, attempted suicide, attempted suicide plus NSSI and neither. There were many significant differences for depression, hopelessness, suicidal ideation, neuroticism, extraversion and conscientiousness (but not openness or agreeableness), anger-in and scores on some scales of the Utrecht Coping List. They concluded that: "Results support a continuum of self-harm such that patients with both non-suicidal self-injury and suicide attempts exhibit significantly greater levels of psychopathology and lower levels of adaptive personality traits and coping skills" (p. 83). However, the NSSI plus attempt versus the attempters only differed only on neuroticism (the combined group higher) and conscientiousness (the combined group lower), but not on any of the other scales.

In a sample of attempted suicides, Schenkel, et al. (2010) found that suicidal intent was associated with the lethality of the attempt. High lethality was associated with male sex and the use of a violent method.

In a study of American homeless adolescents, Yoder, et al. (2010) concluded that:

Multiple attempters, relative to all other youths, evidenced more family, street, psychological and psychiatric problems. Single attempters reported more suicidal ideation than did ideators, and single attempters endured more family problems and were more likely to meet criteria for post-traumatic stress disorder (PTSD) than were nonsuicidal participants. Finally, both single attempters and ideators experienced more psychological problems and number of psychiatric diagnoses than did non-suicidal youths. (p. 151)

In comparing the four groups, there were some linear trends from nonsuicidal, ideators, single attempters to multiple attempters for non-heterosexual orientation, age, most stressors (although a total number of stressors for each adolescent would have been useful), exposure to suicide in family members and friends, trading sex, and physical and sexual victimization on the street.

Adults with Psychopathology

In a sample of college students, Thompson (2010) found that those with more serious behavior (from none, death wish, ideation, planning to attempt) had lower self-esteem linearly. Those at higher levels of suicidality reported having a lower level also.

Andover and Gibbs (2010) studied psychiatric inpatients and found that the presence and number of NSSI episodes were significantly related to presence and number of suicide attempts. Using a suicide intent scale, the authors found that the "patients' history of NSSI (presence and frequency) was more strongly associated with history of suicide attempts than were patients' depressive symptoms, hopelessness, and symptoms of borderline personality disorder, and as strongly associated with suicide attempt history as current levels of suicidal ideation. Finally, among patients with a history of suicide attempts, those with an NSSI history reported significantly greater lethal intent for their most severe attempt, and patients' number of prior NSSI episodes was positively correlated with the level of lethal intent associated with their most severe suicide attempt" (p. 101).

RESEARCH OF NO USE FOR UNDERSTANDING *COMPLETED* SUICIDE

Studies of Attempted Suicide

Adolescents

Nrugham, et al. (2010) followed up Norwegian adolescents from age 15 to 20. Attempted suicide was predicted by being a victim of violence (but not by being a witness of violence), more depressed and less resilient and by not living with both biological parents at age 15.

In a one-year follow-up of a large sample of youths aged 11-17, Roberts, et al. (2010b) found only two predictors of a suicide attempt: marijuana use and suicide attempts by caregiver (including mothers?), but depression at baseline also seemed to me to be a predictor.

Chavira, et al. (2010) found that suicidal ideation and attempted suicide were more common in youths from special education sectors of care than from child welfare, juvenile justice, alcohol and drug services and county mental health sectors. Suicidal behavior was predicted by being female, major depression and being in special education.

In one suburb in Norway, Dieserud, et al. (2010) found that teenagers (aged 13-19) who attempted suicide had different reasons by sex. Girls were more often reacting to relational conflicts and boys to dysfunctional family issues.

In Dutch adolescents, van Wijnen, et al. (2010) found that underweight and overweight (especially obese) boys had a higher incidence of recent suicidal ideation and lifetime attempted suicide. For girls only being overweight (especially obese) was associated with ideation and attempts.

In two national samples of American adolescents, Wolitzky-Taylor, et al. (2010) found that suicidal ideation was associated with attempted suicide (really?) and both were associated with being female, age, drug use, alcohol abuse, indirect violence, PTSD and major depression.

In a sample of adolescents aged 10-19, Barnes, et al. (2010) found that both boys and girls with chronic physical, conditions, mental conditions and both all had a higher incidence of suicidal ideation and attempted suicide independent of race, socioeconomic status, absent parent, special education status, substance use, and emotional distress, and the associations were stronger for the older adolescents.

In a Canadian sample of adolescents aged 14+, Zhao, et al (2010b) found that suicidal ideation and attempted suicide were both more common in those with gay/lesbian/bisexual (GLB) identity and in those who unsure but not in those who were heterosexual with GLB fantasies.

Ramey, et al. (2010) studied a large sample of adolescents in Ontario (Canada) and found that suicidality (ideation and/or attempts) was associated with depression, being female, low self-esteem, poor connections with others, poor coping skills for stress, and concerns about their physical and/or mental health. They also studied the engagement of the adolescents with activities.

> Of the youth engagement measures, unique significant predictive effects were found for seven types of activities, as well as ratings of enjoyment and stress. More specifically, youth reporting that their most important activity was a type of organized clubs/groups, socializing with family or friends, sports or physical activity, education, employment, or volunteering were all at significantly lower risk of suicide than those not reporting an important activity. In contrast, youth indicating that a form of problem behavior (most

> typically substance use) was their most important activity were at significantly greater suicide risk compared to those not reporting an important activity. Further, youth reporting higher (versus lower) levels of enjoyment and lower (versus higher) levels of stress were also at significantly lower levels of suicide risk. (p. 249)

In a sample of Japanese adolescents, Nishida, et al. (2010) found that suicidal ideation and behavior was associated with psychotic-like experiences after controlling for the effects of age, gender, GHQ-12 score, victimization, and substance use.

King, et al. (2010) followed up for one year adolescents hospitalized for suicidal ideation or attempt. Attempting suicide during the follow up was associated with at least one biological parent with mental health problems and baseline reports of multiple previous suicide attempts, more severe suicidal ideation and more severe functional impairment.

Behnken, et al. (2010) found that binge drinking and forced sexual intercourse predicted suicidal ideation and attempted suicide in white and Hispanic adolescent girls but not, they say, in African American girls, but they failed to provide the complete results for the African American girls.

In a sample of Jamaican adolescents, Kukoyi, et al. (2010) found that: “a history of self-violence, violent thoughts toward others, mental health diagnoses other than depression, and a history of sexual abuse were positively associated with suicide attempt. Sexual abuse, mental health diagnoses other than depression, self-violence, and ease of access to lethal substances/weapons were positively associated with suicide ideation” (p. 317).

In a small sample of adolescent attempted suicides at an emergency room, Manor, et al. (2010) found that 65% had ADHD but only one-third of these had been formerly diagnosed with ADHD in the past.

In a national sample of American high school students, Epstein and Spirito (2010) found that attempting suicide by girls was associated with smoking, drinking alcohol before age 13, risky sexual behavior and drug use. For boys, attempted suicide was associated with drinking alcohol before age 13, risky sexual behavior and drug use. Suicidal ideation had similar correlates.

In a study of adolescents (mean age 13.5) in Chicago, Maimon, et al. (2010) found that attempting suicide was associated with being female, older age, African American or Latino ethnicity, depression and mother's education and negatively with two-parent household, number of siblings, parental attachment and support, and length of residence. Neighborhood variables were largely not significant.

In a national sample of American high school students, Swahn, et al. (2010a) found that sadness, weapon carrying, binge drinking, drug use, and low academic grades were significantly associated with suicide attempts, plus physical fighting across settings. Sadness predicted attempted suicide only in all settings, but the other predictors varied with setting.

In adolescents in grades 8-12, Swahn, et al. (2010b) found that attempted suicide was associated with pre-teen drinking alcohol, and with being female, non-white, bullying, weapon carrying, substance use and in grades 8-10..

In a study of adolescent Latinas in America, Kuhlberg, et al. (2010) found that attempted suicide was associated with parent-adolescent conflict, low self-esteem and internalizing behaviors, but not with familism (familial support, familial interconnectedness, familial honor, and subjugation of self to family).

In a study of Mexican American adolescents aged 14-19, Winterrowd, et al. (2010) found that suicidal ideation for girls was associated with a Mexican American identity and friends' school disconnectedness but, for boys, neither variable was associated with attempted suicide.

In a sample of American middle-school students, Hinduja and Patchin (2010) found that suicidal ideation and attempted suicide were associated with experiencing traditional bullying or cyberbullying, as either an offender or a victim. Victimization was more strongly related to suicidal thoughts and behaviors than offending.

Brausch and Gutierrez (2010) found that adolescents who had attempted suicide and also had NSSI, as compared to adolescents with only NSSI had more depressive symptoms, greater suicidal ideation, lower self-esteem and less parental support.

In a study of Chinese adolescents in grades 7-11 and after factor analyzing 17 family variables, Xing, et al. (2010) found that attempted suicide was associated with improper parental rearing behavior, separation from parents, and social

problems of the family members, but not with poor material conditions of family life or family members' adversity.

In a qualitative study of female Latinas aged 11-19 who had attempted suicide, Zayas, et al. (2010) found that:

> the girls were divisible nearly equally into a group with a stated intent of death and a group that did not intend death. The pathways to the suicidal event consisted of a pattern of continuous, escalating stress (primarily at home) that created the emotionally combustible conditions for the attempt. A trigger event that either reminded them of past stress or revived feelings of that stress catalyzed the attempt. Guilt and remorse were common responses to the suicide attempts, and on reflection the girls demonstrated some broader perspectives. (p. 1773)

In a sample of high school students in Rhode Island (USA), Jiang, et al. (2010a, 2010b) found that suicidal ideation was predicted by being female, in grades 9-10, low grades, speaking non-English at home, being LGB, not going to school because of feeling unsafe, forced sexual intercourse, currently smoking and being overweight. Attempted suicide was predicted by being in grades 9-10, not speaking English at home, being LGB, forced sexual intercourse and current smoker. Attempted suicide plus medical treatment had similar predictors.

At the end of a 46-year follow-up study of children in England, Pickles, et al. (2010) compared those with no suicidal thoughts or behavior plus ideation with those with plans and attempts. The plans/attempt group more often had minor depression, worry and irritability as children, higher scores for irritability and neuroticism, affective, anxiety and substance disorders, and experience in childhood of sexual abuse, harsh parenting and poor mother's mental health.

In a sample of adolescents in China aged 12-19, Wang, et al. (2010) found that, for boys, suicidal ideation was predicted by sad/hopeless, and current drinking. Participating in vigorous physical activities ≥3 times/week was a protective factor. Attempted suicide was predicted by having has sexual intercourse. For girls, attempted suicide was predicted by physical fighting and suicidal ideation by considering themselves overweight and current smoking. However, almost all of the health risk behaviors were correlated with suicidal ideation and attempts for both boys and girls.

In a sample of high school students in Hong Kong, Wan and Leung (2010) found that attempted suicides scored higher than suicidal ideators who scored higher than nonsuicidal youths for parents divorced/separated, physical abuse, poor family relationships, frequent life stressors, externalizing problems and internalizing problems.

Baumann, et al. (2010) studied adolescent Latinas who had attempted suicide versus those with no attempt. They found that gaps in familism (mothers scoring higher than their daughters on the scale) predicted less mother-daughter mutuality and more externalizing and internalizing behaviors in the adolescents and this predicted suicide attempts.

In a study of rural European American adolescents (aged 11-19), Boeninger, et al. (2010) found that:

> "peak levels of past-year ideation and plans occurred during mid adolescence for girls, but slowly increased through late adolescence for boys. We found that prevalence patterns for attempts were very similar for boys and girls, with both increasing through mid adolescence and then declining, although girls' risk declined slightly more rapidly." (p. 451)

Chronis-Tuscano, et al. (2010) followed up for 14 years children aged 4-6 with ADHD and those without ADHD. The children with ADHD more often developed depression, suicidal ideation and attempted suicide. For those with ADHD, the girls more often attempted suicide, and maternal depression and concurrent child emotional and behavior problems at 4 to 6 years of age predicted depression and suicidal behavior.

In a sample of South Korean middle and high school adolescents, Kim and Lee (2010) found that suicidal ideation was associated with overestimation of weight (and behaviors to lose or gain weight for boys and overestimation of weight and attempting to lose weight for girls. Suicide attempts for boys were associated with trying to lose, gain, or maintain their weight and, for girls, underestimating their weight and trying to lose weight. Boys and girls classified as overweight or at risk for overweight were less likely to report suicide attempts compared to those classified as underweight.

In Rotterdam (the Netherlands), van Bergen, et al. (2010) studied girls aged 14-16 and found that female rates of attempted suicide were higher for Turkish and South Asian-Surinamese than for Dutch females, while Moroccan females had

lower rates Physical and sexual abuse and an impaired family environment, as well as parental psychopathology or parental substance abuse, contributed to attempted suicide for all ethnicities.

In a sample of adolescents, Pace and Zappulla (2010) found that, for boys, suicidal ideation was predicted by depression and detachment (a component of emotional autonomy from parents) but not by separation (the other component of emotional autonomy), while for girls, only depression predicted suicidal ideation.

Tang, et al. (2010) studied Taiwanese aboriginal adolescents who experienced Typhoon Morakot-associated mudslides. Suicidality (attempts plus ideation) was associated with the degree of exposure to and personal impact from the mudslides, as well as female gender, PTSD and major depressive disorder, and low family support.

Cloutier, et al. (2010) studied adolescents presenting at an emergency department and found that those who had attempted suicide had the highest level of depressive symptoms, suicidal ideation and impulsivity.

In American 11-13 year-old school students, Gunter and Bakken (2010) found that suicidal behavior (thoughts and actions) were predicted negatively by emotional comfort, satisfaction with self, resilience, and school type (elementary versus middle-school: higher in middle-school).

In depressed adolescent psychiatric outpatients, Csorba, et al. (2010) found that suicidal adolescents (undefined) scored higher for novelty-seeking and lower for persistence, but no different on harm avoidance, reward dependence, self-directedness, cooperativeness and self-transcendence.

Sarkar, et al. (2010) compared children <12 years of age and adolescents presenting at a children's hospital with suicidality. The children were less often in residential care, used overdoses less often, and were more often with only suicidal ideation. The children more often had been bullied and had a family history of depression, and less often had a history of suicidality and were less often admitted.

In a national survey of American adolescents, Winfree and Jiang (2010) studied 19 variables to predict suicidal ideation and attempts. There was, unfortunately, no factor analysis of the variables and no multiple regressions. Suicidal behavior "can be understood in terms of *social support and certain individual factors*, some common to both ideation and attempts, others unique to

one or the other. Moreover, suicide ideation and attempts were linked to the risk-taking behaviors of the youths, their friends, and their family members. Feeling safe at school was one of the most consistent protective factors included in the study" (p. 19). From the table of results, it appears that attempted suicide was associated with prior suicidal ideation and attempt, smoking, a family member attempting suicide, and lack of parental support and school safety. Suicidal ideation had similar associations.

In a sample of LGBT youths (aged 16-20), Mustanski, et al. (2010) found that suicidal ideation was predicted by being female but not by sexual orientation or ethnicity. Attempted suicide was not predicted by any of these three variables.

Adults

In a sample of psychiatric inpatients who had attempted suicide, O'Connor, et al. (2010) found that, on a Suicide Upset Assessment Scale, the subscale scores for behavioral response and psychosomatic body were associated with the number of attempts and the severity of attempts. Scores for focus, motivating factor, psychosomatic mind and perceived burdensomeness were not associated with the number of attempts or the severity of attempts.

In a national sample of Americans, Lizardi, et al. (2010b) found that females (but not males) who lived with a stepparent were more likely to report a lifetime suicide attempt compared with females who had not.

Joyce, et al. (2010) studied adults who had been treated for depression. They found that suicide attempts were most common in those with bipolar-I disorder and in those with borderline personality disorder. In a multiple regression, only harm avoidance on Cloninger's Temperament and Character Inventory contributed to the prediction of suicide attempts.

In American Hispanics in New York and Puerto Rico, Jennings, et al. (2010) found that the children of parents who had attempted suicide were delinquent more frequently and in more varied ways. Other family variables were also significantly associated with delinquency.

In a national American sample, Mota, et al. (2010a) found that attempted suicide and suicidal ideation were both more common in those with age of first intercourse between 12 and 14 (versus 15-17) and those with two or more partners

in the past year. Never married participants who rarely/never used condoms were more likely than those who always used condoms to report suicide attempts.

In a national sample of attempted suicides, Miller, et al. (2010b) found that alcohol was involved more often in men, blacks and those aged 30-55.

Sisask, et al. (2010) compared attempted suicides in Estonia with community controls. The attempted suicides less often reported a religious affiliation. In four countries, attempted suicides less often reports a religious affiliation or subjective religiosity (Brazil, Iran, South Africa and Sri Lanka) but not in two countries (India and Vietnam).

Preti, et al. (2010) studied a nationwide sample of patients admitted to psychiatric hospitals in Italy. Those who had attempted suicide more often had disordered eating behavior, depressive symptoms, substance abuse and non-prescribed medication abuse, and a traumatic event in the week prior to admission. Symptoms of psychosis (hallucinations/delusions) and lack of self-care were negatively associated with suicide attempt admission.

In a national sample in Mexico, Borges, et al. (2010b) found that suicidal ideation and attempted suicide were associated with having a psychiatric disorder, especially conduct disorder and alcohol abuse/dependence.

In samples of undergraduate students in Nicaragua, El Salvador, Chile and Spain, Vázquez, et al. (2010a) found that stressful life events (e.g., physical or sexual mistreatment, excessive alcohol or drug consumption, having left home during childhood or adolescence, etc.) predicted attempted suicide for the students as a whole.

In a sample of all Swedish men born during 1950-1976, Whitley, et al. (2010) found that, with increasing height, attempted suicide was less common overall and by all methods except drowning, even after adjustments for psychiatric illness, marital status and socio-economic status.

Scott, et al. (2010) studied 40,000 people in 14 countries. They concluded:

> Most physical conditions were associated with suicidal ideation in the total sample; high blood pressure, heart attack/stroke, arthritis, chronic headache, other chronic pain, and respiratory conditions were associated with attempts in the total sample; epilepsy, cancer, and heart attack/stroke were associated

> with planned attempts. Epilepsy was the physical condition most strongly associated with the suicidal outcomes. Physical conditions were especially predictive of suicidality if they occurred early in life. As the number of physical conditions increased, the risk of suicidal outcomes also increased. (p. 712).

In a sample of female sex workers in China, Hong, et al. (2010) found that suicidal ideation and attempted suicide in the past six months were associated with their self-perceived stigma. Women of ethnic minorities other than Zhuang, from urban areas or with low level of education were more likely to report suicidal ideation. Women who lived with family or boyfriends were also more likely to report a suicidal attempt.

In a sample of attempted suicides, Miret, et al. (2010) found that older (55+) attempters had higher suicidal intent. Suicidal intent was associated with previous attempts, mood disorder, personality disorder, substance disorders and psychosis. The two age groups differed on some of these variables with the older attempters more often having chronic illness and mood disorders and less often personality disorder.

Neilssen, et al. (2010) studied those attempting suicide in Australia by jumping who survived and found that 44% could be diagnosed as having a psychotic disorder.

In data from 21 countries, both developed and developing, Borges, et al. (2010a) found similar rates of suicidal ideation and attempts in them. The researchers concluded:

> Risk factors for suicidal behaviors in both developed and developing countries include: female sex, younger age, lower education and income, unmarried status, unemployment, parent psychopathology, childhood adversities, and presence of diverse 12-month DSM-IV mental disorders. Combining risk factors from multiple domains produced risk indices that accurately predicted 12-month suicide attempts in both developed and developing countries." (p. 2)

In a study of college students, Troister and Holden (2010) found that suicidal ideation (total, preparation and motivation), past attempted suicide and number of past attempts (for those with at least one attempt) were associated with depression, hopelessness and Holden's measure of psychache.

In three samples (high school students, college students and military recruits), Klonsky and May (2010) found that ideators did not differ from attempters in overall impulsivity. In a scale that measured aspects of impulsivity, ideators and attempters scored similarly for urgency (the tendency to act impulsively in the face of negative emotions), but attempters scored lower for premeditation (a diminished ability to think through the consequences of one's actions). The two groups did not differ in sensation seeking or lack of perseverance. The suicidal subjects scored higher for urgency than the non-suicidal subjects.

In a 4-5 year follow-up of an Australian national sample, Fairweather-Schmidt et al. (2010) found that the persistence of suicidal behavior (ideation and attempts) varied with sex, age, marital status, being employed and the presence of a physical illness.

Dale, et al. (2010) studied a sample of patients presenting at an emergency room with suicidal behavior (undefined). Compared to a clinical control group, the suicidal group had higher scores for anxiety, depression and early maladaptive schemas, but not on measures of parental care or control. For the suicidal group, a measure of the risk of repetition (anti-social personality, problem alcohol use, not living with a relative, previous outpatient psychiatric care, previous suicidal behavior hospital admission and previous inpatient psychiatric care) was associated with scores for parental control and care and early maladaptive schemas.

In a large sample of American adults, McMillan, et al. (2010) found that suicidal ideation and attempted suicide were more common in those with lower income, but the association differed by ethnicity (stronger for non-Hispanic whites).

In a study of an American national sample, Nock, et al. (2010b) found that attempted suicide was associated with a mental disorder, including anxiety, mood, impulse-control and substance abuse disorders, as well as comorbidity. Depression predicted suicidal ideation, but not attempted suicide.

In a national survey, Lizardi, et al. (2010a) say that they found that female offspring of parental divorce and parental remarriage are more likely to report a lifetime suicide attempt than male offspring even after controlling for offspring depression. However, their report is poor. It also appears that parental divorce increased the risk of attempted suicide in women compared to those who parents

stay married. Parental remarriage increased the risk of attempted suicide for women but not for men.

In active-duty U.S. Air Force members, Snarr, et al. (2010) found that suicidal ideation was associated with female gender, low rank, and non-Christian religious affiliation and, for men, being unmarried. Attempted suicide was more common in low-ranking men and Hispanic women.

In a large sample of adults in South Korea, Jeon, et al. (2010b) found that, for those with suicidal ideation, suicidal ideation plus plan, one suicide attempt and multiple suicide attempts, there was a linear increase in younger individuals and in diagnoses of mood disorders (especially bipolar disorder) and anxiety disorders and PTSD, but not alcohol use disorders.

Bi, et al. (2010) compared attempted suicides in China with and without a psychiatric disorder. Those with no psychiatric disorder were younger, had higher levels of impulsiveness and were more likely to have ideas about being rescued. Those with a psychiatric disorder were more often female, with more than six years of formal education, had a higher score on a suicidal ideation scale, a higher score on the Hamilton depression rating scale, and a lower score on a quality of life scale

In a sample of women in Tajikistan, Haarr (2010) found that suicidal ideation was associated with physical abuse by the husband and by the mother-in-law and sexual abuse by the husband. Attempted suicide was associated with physical abuse by the husband and by the mother-in-law. Suicidality was also associated with telling someone about the abuse.

Ventrice, et al. (2010) compared small samples of patients at a crisis unit who had attempted suicide and who not done so. The description of results is obscure, but the only significant difference reported was that the attempters had witnessed more suicidal behavior by others.

In sample of adults in 21 countries, Bruffaerts, et al. (2010) found that childhood adversities predicted adult suicidal ideation and attempts. The more adversities, the more often suicidal behavior. Sexual and physical abuse were the strongest predictors. The associations remained after controlling lifetime psychiatric disorder.

In a sample of attempted suicides followed up for three years, Waern, et al. (2010) found that a repeat attempt was predicted by age, sex, anxiety and depression scores, major depression and scores on a suicide assessment scale (which measured sadness/despondency, tension, emotional withdrawal, perceived loss of control and suicidal thoughts).

Wiktorsson, et al. (2010) compared elderly attempted suicides seen at emergency rooms with community controls. The attempters were more often unmarried, living alone, with perceived loneliness, low education and a history of psychiatric treatment and prior attempted suicide.

Kuramoto, et al. (2010) compared the offspring of parents one of whom died by suicide or by accidental causes. The offspring of maternal suicide, but not of paternal suicide, were at higher risk for attempted suicide requiring hospitalization than the accidental death group.

Cukrowicz, et al. (2010) found that psychiatric patients with major depression who participated in suicide research did not experience attempted suicide or an increase in suicidal ideation after participation.

In a sample of Hispanic adults, Chang, et al. (2010a) found that suicidality (ideation or attempts) was associated with negative life events, loneliness and hopelessness.

In a national survey in Great Britain, Bebbington, et al. (2010) found that the presence of suicidal ideation, death wishes and tedium vitae predicted attempted suicide.

In a sample of community dwelling elderly women, Lau, et al. (2010) found that those who had attempted suicidal or had suicidal ideation had lower resilience and personal and interpersonal control and higher psychological distress, demoralization and feelings of hopelessness.

In a study of Austrian university students, Plöderl, et al. (2010a) found that attempted suicide was more common in those with homosexual or bisexual fantasies, partner preference, behavior, and self-identification.

In a study of Austrian gay and bisexual Austrian adults, Plöderl, et al. (2010b) found that past school-related attempted suicide was associated with lack

of acceptance at school and harassment experiences. They excluded non-school-related attempted suicides!

In a sample of fertile women who had attempted suicide, Baca-Garcia, et al. (2010) found that suicide attempts were more likely to occur during menses. Compared to women whose attempts occurred during other phases, women who attempted suicide during low estradiol/low progesterone states (menstrual phase, amenorrhea and menopause) had more severe suicide intent,

In South Korea, Jeon, et al. (2010a) studied planned versus unplanned attempted suicides. The unplanned attempters had less education and had fewer past attempts and less often reported previous suicidal ideation, but did not differ in age, sex, marital status and unemployment. The unplanned attempters used chemical agents (but not medications) and falling more often. The unplanned attempters more often had alcohol use disorder, major depressive disorder, posttraumatic stress disorder, and bipolar disorder.

In a community sample in Brazil, Coêlho, et al. (2010) found that suicidality (ideation and attempt) was predicted by major depression, dysthymia and alcohol and drug disorders.

In a sample of military personnel who served in the Iraq war, Bryan, et al. (2010a) found that combat experience predicted the acquired capability for self-harm, but not perceived burdensomeness or thwarted belonging (variables in Joiner's interpersonal theory of suicide). Scores on the Suicide Behaviors Questionnaire were associated with PTSD symptoms, combat experience, depression, perceived burdensomeness and thwarted belonging but not with the acquired capability for self-harm.

In a national sample in America, Nepon, et al. (2010) found that attempted suicide was associated with anxiety disorders, especially panic disorder and PTSD and especially when these were comorbid with a personality disorder.

Bjomaas, et al. (2010) studied attempted suicides by self-poisoning and compared those whose attempts were related to substance abuse with the others. The substance abuse subjects were less often aged >30, Asian immigrants, living with parents, on sick leave (versus employed), with past attempted suicide, and less likely to have received prior psychiatric treatment. They also compared attempted suicides with those judged to be making an appeal using self-poisoning. The only difference was that appeal subjects were more likely to be female.

Zhao, et al. (2010a) studied serious attempted suicides in China. They found that attempters <20 years of age were less likely to use alcohol at the time of the attempt. Attempters aged 20-44 years had less regular contact with family members but were more likely to make the attempt in the presence of someone else. Attempters > 45 years were more likely to have high suicidal intent, lower quality of life, mood disorders, and substance abuse disorders.

Daini, et al. (2010) compared attempted suicides, depressed patients and normal controls on a projective test (the Wartegg Test). The attempters differed from the depressed patients on only one of eight measures, and from the controls on three measures.

In a study of South Korean adults, Park, et al. (2010d) found that problem and pathological gamblers more often reported suicidal ideation and past attempts, as well as more often having a substance abuse disorder.

In a study of 102,245 people in 21 countries, Stein, et al. (2010) found that suicidal ideation and past attempted suicide was associated with a history of traumatic events, and there was an impact from the number of traumatic events and also for the type of event.

In a sample of patients seen at VHA medical center, Hendin, et al. (2010) found that a scale to measure the intensity of nine affects predicted suicidal behavior in the following three months. Having a disability and substance abuse both added to the prediction.

Rasmussen, et al. (2010) compared first-time attempters, repeat attempters and acute patients with physical issues. The first-time and repeat attempters did not differ in defeat, entrapment (internal, external and total), social support, depression or anxiety, but the repeaters had less positive future thinking. Both groups differed, of course, from the controls. Suicidal ideation was associated with all of these variables for the attempted suicides, as expected. They report regressions instead of factor analyzing the variables to identify clusters of related variables. They phrase their study as testing the Cry of Pain model rather than the defeat-entrapment model.

Psychiatric Patients

In a sample of patients with depression or anxiety disorders, Glashouwer, et al. (2010) found that automatic self-associations of depression and anxiety, both implicit and explicit, (assessed by the Implicit Associations Test) were related to suicidal ideation and past suicide attempt.

Cha, et al. (2010) studied a sample of patients presenting at a psychiatric emergency department who were given an emotional Stroop task and followed for six months. Suicide attempters showed an attentional bias toward suicide-related words (but not generally negative valenced words) relative to neutral words above and beyond their clinical variables.

Burke, et al. (2010) studied the offspring of patients with mood disorder. The offspring exposed to suicidal behavior of their parents or by others were more likely to have attempted suicide. However, analysis of exposure occurring before the age at their first suicide attempt found no association between exposure and suicide attempt, thereby ruling out imitation.

In a sample of Turkish psychiatric patients, Arkar (2010) found that attempted suicide was associated with higher scores for novelty seeking and harm avoidance and lower scores for self-directedness and cooperativeness on Cloninger's Temperament and Character Inventory.

In a poorly designed study (the history of attempted suicide was not known for 73% of the sample), Yaseen, et al. (2010) devised a scale to predict past attempted suicide in psychiatric inpatients. Their scale produced two factors: near-psychotic somatization and ruminative flooding, while the second described frantic hopelessness. However, looking at the items of the scale, Yaseen, et al. concluded that attempted suicide was associated with ruminative flooding, doom, hopelessness, entrapment and dread.

In a sample of patients at an emergency psychiatric unit, Nock, et al. (2010a) found that those who had attempted suicide (or who attempted suicide in the following six months) had a significantly stronger implicit association between death/suicide and self (using a brief computer-administered test that uses people's reaction times when classifying semantic stimuli to measure the automatic mental associations they hold about various topics, in this case, life and death/suicide).

Kraft, et al. (2010) asked a sample of patients in the hospital for suicidal ideation or attempted suicide why they would die by suicide. They coded the responses as:

- the easy way out
- a permanent solution
- an escape from pain
- the only option
- self-oriented
- related to hopelessness
- relationally

In a sample of patients with borderline personality, Maddock, et al. (2010) compared those engaging in NSSI and attempted suicides. They did not differ in psychiatric comorbidities, but the NSSI were more educated. The attempted suicides more often gave reasons of avoidance/escape and interpersonal communication and influence. The NSSI patients more used cutting and attempted suicides poisoning.

In a national sample of non-institutionalized Americans, Bolton and Robinson (2010) found that the four disorders more strongly associated with high rates of attempted suicide were: major depressive disorder, borderline personality disorder, nicotine dependence, and posttraumatic stress disorder, but most disorders were associated with attempted suicide.

In a national survey in Finland, Suokas, et al. (2010) found that: "Of persons with a lifetime history of any primary or substance-induced psychotic disorder…, 34.5% (women: 34.1%, men: 34.9%) had a history of at least one suicide attempt. There were no suicide attempts among persons with delusional disorder, while the rate of suicide attempts was higher among persons with substance-induced psychotic disorders (48.8%) than in persons with other psychotic disorders 41.8%). Suicide attempts were associated with younger age, comorbid substance use disorders, depressive symptoms, and physical violence against other people" (p. 22).

In a sample of psychiatric outpatients, Li, et al. (2010) found that lifetime and past year attempted suicide were associated with frequent insomnia and recurrent nightmares.

In a sample of adolescent psychiatric inpatients, Greening, et al. (2010a) found that past attempted suicide was related to being female, depression and reactive aggression but not to proactive aggression.

Greening, et al. (2010b) studied young (aged 6-12) psychiatric inpatients and found that current and past suicidal behavior (presumably ideation or attempted suicide) was predicted positively by age, depressive symptoms and reactive aggression and negatively with authoritarian parenting. The presentation of their results is poor, but the results may have differed for white and African American children.

Mellesdal, et al. (2010) studied psychiatric readmissions after a mean follow-up of 562 days. Suicidal risk (ideation or attempts) as a reason for readmission was predicted by substance use disorders, personality disorders, prior psychiatric hospitalization, unemployment, and receipt of social benefits.

Affective Disorder

In a sample of bipolar disorder patients, Gomes, et al. (2010) found that those who were obese were twice as likely to have a history of attempted suicide.

In patients with major depressive disorders, Jandi, et al. (2010) compared those making "hard" attempts, "soft" attempts and no attempts. Those making hard attempts had higher anger-in scores.

In a sample of psychiatric outpatients with bipolar disorder-II (BP-II) and major depressive disorder, Rihmer and Benazzi (2010b) found that suicide threats/attempted were higher in those with BP-II, impulsivity and affective instability. In multiple regressions, only impulsivity predicted suicidality.

In study of a sample of the general population with two or more depressive symptoms, Spijker, et al. (2010) found that being male, a longer duration of depression, anhedonia, feeling worthless, comorbid anxiety, previous suicidal ideation and use of professional care predicted suicidal ideation. Attempted suicide was predicted by living without a partner, comorbid anxiety and previous suicidal ideation and suicidal acts.

In a sample of psychiatric outpatients with bipolar-II disorder or major depression, Rihmer and Benazzi (2010a) found that threats or attempts were predicted by trait impulsivity and chronic emptiness and not by affective instability

(traits of borderline personality disorder [BPD]). BPD was more common in the bipolar patients than in those with major depression.

In a sample of patients with major depressive disorders, Perroud, et al. (2010) found that those who had past attempted suicide had more severe depression (mean Montgomery-Asberg), a higher level of suicidal ideation, a younger age of onset, had experienced more depressive episodes, had higher harm avoidance scores and a worse socio-demographic environment than non-attempters.

Smith, et al (2010) compared depressed suicidal ideators and attempted suicides with normal controls. Suicide attempters had the highest levels of fearlessness and pain insensitivity and a greater history of painful and provocative life events in line with Joiner's Interpersonal Theory of Suicide, but did not differ on a psychophysiology test (eye-blink response to a startle probe while viewing pictures of varying hedonic valence). The ideators and controls had similar scores.

In a study of psychiatric outpatients and primary care patients with major depression, Hantouche, et al. (2010) found that attempted suicide was associated with a family history of suicide and mood disorders, not being married, recurrence of depression, the "irritable–risk-taking" dimension of hypomania, substance abuse, and the need for psychiatric treatment.

In a sample of depressed Americans, Uebelacker, et al. (2010) found that attempted suicide was less common than suicidal ideation and that the suicidal individuals were more depressed!

In a sample of bipolar disorder patients, Altamura, et al. (2010) found that those with a longer duration of untreated illness (>2 years) had more often attempted suicide and made more attempts.

In a sample of bipolar patients, Neves, et al. (2010) found that those making violent attempts (versus non-violent attempts) had an earlier illness onset and a greater number of psychiatric comorbidities (borderline personality disorder, panic disorder and alcoholism).

Grunebaum, et al. (2010) studied patients with a major depressive disorder and found that less secure/more avoidant attachment on the Adult Attachment Scale and poorer social adjustment predicted attempting suicide during a one-year follow-up

In a three-year follow-up study of patients with major depressive disorder, Bolton, et al. (2010) found that attempted suicide was predicted by comorbid anxiety disorder and substance use disorders as well as PTSD and dependent personality disorder.

In a sample of depressed psychiatric patients in South Korea, Park, et al. (2010b) found that attempted suicide was associated with younger age, experience of significant life events before 12 years of age, psychotic symptoms, and previous depressive episodes, as well as scores for depression, anxiety, quality of life and global functioning.

In a sample of patients with bipolar disorder, Oquendo, et al. (2010) found that those with comorbid alcohol use disorder had attempted suicide more often. Nicotine dependence and drug use disorders did not increase the incidence of attempted suicide.

In a follow-up study of patients with major depression for five years, Holma, et al. (2010) found that attempted suicide was associated with the months spent with the major depression episode and in partial remission, a history of suicide attempts, lack of a partner and low perceived social support, as well as depression, anxiety, hopelessness and Cluster A traits.

In a small sample of depressed patients, Jollant, et al. (2010) found that the attempted suicides had worse performance on a gambling task.

Azorin, et al. (2010) compared patients with major depressive disorders who had attempted suicide versus those who had not. The attempters had had a longer duration of illness, longer delays before seeking help and obtaining a correct diagnosis, a higher number of previous episodes, more often rapid cyclers, with fewer free intervals between episodes, more comorbidity with bulimia and substance abuse bipolar-II spectrum disorders, with depressive, cyclothymic and irritable temperaments and a family history of both affective disorder and suicide attempts.

Compared to community controls, An, et al. (2010b) found that attempted suicides scored higher for impulsivity and on the Buss-Perry Aggression Questionnaire for all subscales.

Dombrovski, et al. (2010) compared elderly (>60) depressed individuals who had attempted suicide or had suicidal ideation with nonsuicidal depressed individuals and normal controls. They found:

> Suicide attempters but not suicide ideators showed impaired probabilistic reversal learning compared to both nonsuicidal depressed elderly and nondepressed comparison subjects, after controlling for effects of education, global cognitive function, and substance use. Model-based analyses revealed that suicide attempters discounted previous history to a higher degree relative to comparison subjects, basing their choice largely on reward/punishment received on the last trial. Groups did not differ in their performance on the Stockings of Cambridge test. (p. 699)

Moreira, et al. (2010) found no differences in past attempted suicide between bipolar-I and bipolar-II patients.

Guillaume, et al. (2010) studied patients with recurrent major depressive disorder and bipolar disorder who had attempted suicide. The bipolar patients had made more serious attempts and more often had a family history of suicide, as well as eating disorders and higher affective intensity.

Antypa, et al. (2010) studied recovered depressed patients. Past attempted suicides had higher hopelessness reactivity and higher aggression reactivity than the non-suicidal and suicidal ideation groups on a cognitive reactivity test. Suicidal ideation during a depressive episode was associated with elevated hopelessness reactivity scores during remission independently of anxiety disorder comorbidity.

In patients with major depressive disorders, Olié, et al. (2010) found that those with recent or lifetime attempts suicide had higher levels of current psychological pain and a higher intensity and frequency of current suicidal ideation, but did not differ from non-attempters in physical pain.

Brown, et al (2010) compared patients with major depressive disorder with and without panic-agoraphobic disorder (PAS). Those with PAS were more likely to have had a suicide attempt history, higher current depression severity and higher current suicidal severity even after controlling for the overall depression severity and other clinical factors

Schizophrenia and Psychosis

Shrivastava, et al. (2010) followed up 61 schizophrenic patients who had shown improvement after treatment for ten years. Subsequent suicidal ideation and attempts was not predicted by any of the baseline socio-demographic and clinical variables.

Levine, et al. (2010) followed up schizophrenics for 4-7 years and found that those with a past attempt at the time of first admission were more often college educated, female and not married. Attempting suicide during follow-up was associated with the same variables plus a prior attempt.

In a sample of psychotic patients on their first admission and followed up for four years, Bakst, et al. (2010a) found that subsequent attempted suicide was predicted at admission by prior attempts or ideation, severity of depressive symptoms and thought disorder, lifetime substance abuse, and a younger age. Suicide ideation was predicted by the same variables with the addition of insight into illness and with the exception of age at admission.

Bakst, et al. (2010b) found that past attempted suicide in first admission patients with psychosis was associated with poor/declining premorbid functioning, which also predicted further attempts in the following four years.

In a 7-year follow-up of patients with first episode psychosis, Robinson, et al. (2010) found that attempted suicide was associated with a history of self-harm, being depressed for >50% of the initial psychotic episode, hopelessness, and a history of problem alcohol use.

Taylor, et al. (2010a) found that patients with schizophrenia who had attempted suicide scored higher on a test of specific memories than those who had not attempted suicide, especially for memories that were currently distressing. The attempters scored high on trait anxiety and depression but not for duration of illness.

Pratt, et al. (2010b) compared patients with non-affective psychosis who had attempted suicide or not on an interesting but flawed cognitive task to measure suicide schemas. They had the patients sort a set of 100 suicidal concepts into an order which they viewed as most related through to least related to the overarching concept of suicide. The study is flawed because the researchers chose the 100 concepts, and so they are not getting at the patients' schemas. An analogy is

George Kelly's REP test which allows subjects to choose *their own* adjectives to describe people rather than using adjectives provided by the researcher. The attempters were more depressed, hopeless, anxious and with more suicidal ideation. The researchers concluded: "The suicide schema for the suicide group was more elaborate and extensive than for the non-suicide group (p. 1211).

In a sample of first episode psychotics, Upthegrove, et al. (2010) found that attempted suicide was predicted by depression in prodomal phase.

In a sample of schizophrenic inpatients, Pettersen, et al. (2010) found that those who had attempted suicide did not differ in depression or hopelessness, but the attempters more often had an over-general autobiographical memory.

Using the Examination of Anomalous Self-Experience scale with a sample of schizophrenics, Skodar and Parnas (2010) found that suicidal ideation, but not attempted suicide, was associated a measure of self-presence but not with measures of stream of consciousness, bodily experience or demarcation.

In a national Swedish sample of over one million men followed-up for 24 years, Batty, et al. (2010) found that a lower IQ measured in early adulthood predicted later attempted suicide by any methods. For those later diagnosed with psychosis there was no association.

Iancu, et al. (2010) found that scores on a suicide risk scale for male schizophrenics were associated with impulsivity, older age, higher levels of overt aggression scores, and an elevated score on the general psychopathology subscale of the PANSS.

In a sample of patients with first episode psychosis, Barrett, et al. (2010b) found that attempted suicide in the past was associated with female gender, more depressive episodes, younger age at psychosis onset, and a history of alcohol disorder. Attempted suicide after admission but before treatment was associated with more depressive episodes and younger age at illness onset, in addition to drug use the last six months and longer duration of untreated psychosis.

Cohen, et al. (2010b) compared elderly (>55) schizophrenics who develop schizophrenia before age 45 and living in the community with community controls. The schizophrenics had more past suicidal ideation and attempted suicide. For the schizophrenics, lifetime attempted suicide was associated with current depression and higher scores on the Traumatic and Victimization Scale.

In patients with first-episode schizophrenia spectrum psychosis studied for two years after the start of treatment, Melle, et al. (2010) found that plans and attempts were predicted by drug abuse, dissatisfaction with life and severe suicidality at start of treatment.

Substance Use Disorder

In a sample of attempted suicides, Boenisch, et al. (2010) classified them into four types: alcohol use before the attempt plus alcohol use disorder, alcohol use disorder only, alcohol consumption only and neither. The four groups differed by age, sex, the lethality of the method used, and prior attempts. For example, attempts by those with alcohol use disorder were more often committed by men and older individuals while, when alcohol was consumed in suicide attempt by individuals with alcohol use disorder, methods less likely to result in death were used more often.

In a sample of illicit drug users, Darke, et al. (2010) found that attempted suicide was associated with NSSI and experience of violent assaults.

Roy (2010) found that attempted suicides in heroin users were younger; more often female, with childhood trauma, a family history of suicidal behavior, a history of aggression, treatment with antidepressant medication, and alcohol and cocaine dependence.

In a one-year follow-up study of patients treated for substance abuse disorders, Britton and Conner (2010) found that male sex, older age, and minority race or ethnicity were associated with a lower likelihood of attempted suicide. Depression and previous suicidal ideation or attempts predicted a greater likelihood of attempted suicide during the follow-up.

In a sample of heroin addicts, Chen, et al. (2010c) found that past-month attempted suicide was associated with the severity of heroin dependence, needle sharing, a higher educational level, increased levels of depression, and the number of stressful life events.

In a sample of depressed patients with alcohol dependence or abuse, Yaldizli, et al. (2010) found that attempted suicide was predicted by currently in treatment for alcoholism, drinking experiences like being sick in the stomach or palpitations, bad experiences from drug use generally, delusions or hallucinations

during depressive episodes, suicide ideation, any form of antidepressant treatment and a positive family history for alcoholism.

In a national survey of adults, Howard, et al. (2010) found that those who used inhalants or who had inhalant use disorder had higher rates of suicidal ideation and attempted suicide.

In a sample of patients with substance abuse disorders, Ilgen, et al. (2010d) found that those with prior violence inflicted by themselves on others were more likely to report suicidal ideation and both single and multiple attempts. The more extreme forms of violence (i.e., murder, rape) were most strongly associated with the risk of multiple suicide attempts. Suicidal ideation was more common in those who were female, older and with a high school diploma, symptoms of depression and to have been the victim of childhood physical and/or sexual abuse. Violence against others was most strongly associated with multiple attempts. The authors did not disentangle violence as perpetrator and as victim.

In a study design that makes no sense, Maloney, et al. (2010) combined opioid addicts and community controls and found that, for the combined sample, a history of multiple attempts at suicide (and other factors) predicted self-mutilation.

Personality Disorders

In a sample of attempted suicides, Blasco-Fontecilla, et al. (2010) found that the life events associated with attempting suicide varied by personality disorder (PD). For example, death of a spouse was associated with antisocial PD while being fired at work was associated with narcissistic PD.

Nisenbaum, et al. (2010) focused on a sample of patients with borderline personality disorder (BPD) and recurrent suicidal behavior. Patients reporting moderate to severe sexual abuse and elevated suicide ideation were characterized by worsening moods from early morning up through evening. Patients reporting mild sexual abuse and low suicide ideation reported improved mood throughout the day.

In a sample of attempted suicides with BPD, Chesin, et al. (2010) found that impulsivity was associated with both the lethality of the most recent attempt and the number of prior attempts. They presented a path analysis, and it appears that aggression, alcohol use and objective planning played a role.

Using data from a national survey, Lentz, et al. (2010) found that people with schizotypal personality disorder were more likely to have attempted suicide, even after controls for socio-demographic variables, Axis-I and Axis-II disorders and childhood adversity.

In a study of female outpatients with borderline personality disorder with or without PTSD who had attempted suicide or had NSSI (a bad choice), Harned, et al. (2010) found that those with PTSD had less suicidal intent and made less lethal attempts. The lesser lethality and intent is probably a result of the including NSSI.

Maurex, et al. (2010) studied attempted suicide in women with BPD and compared them to normal controls. They concluded that patients with: "BPD showed reduced specificity of autobiographical memory, irrespective of either concurrent depression, previous depression, or concurrent PTSD. The depressed BPD group displayed poor problem-solving skills. Further, an association between unspecific memory and poor problem-solving was displayed in the BPD group" (p. 328). (I had to carefully check the description of subjects for this research because I could not believe that the authors choose a normal control group!)

In a sample of obsessive-compulsive patients followed-up for four years, Alonso, et al. (2010) found that those with persistent suicidal ideation scored higher on a depression scale, more often had an affective disorder and more often avoidant personality disorder. Those who attempted suicide (n=11) or completed suicide (n=2) more often had persistent suicidal ideation, scored higher for depression, were single and had a history of attempted suicide, more often had comorbid affective disorder and avoidant personality disorder and more often had obsessions concerning the need for symmetry and ordering compulsions

Eating Disorders

In a sample of adolescent psychiatric inpatients, Zaitsoff and Grilo (2010) found that all aspects of eating disorder psychopathology (dietary restriction, body dissatisfaction, binge eating, and self-induced vomiting) was associated for girls and for boys with suicidal risk (undefined) after controlling for depressive/negative affect. For the girls, suicide risk was also associated with depression, hopelessness, anxiety and self-esteem. These associations were similar for past attempted suicide.

In sample of patients with anorexia, Selby, et al. (2010) found that attempted suicide was associated with depression and BPD, with binging/purging versus

restriction and with both eating disorder painful behaviors and non-eating disorder painful behaviors.

In a small sample of females with eating disorders, Fennig and Hadas (2010) found that attempted suicide was associated with depression, a history of sexual abuse and a longer duration of illness, while suicidal ideation was associated only with depression. Some subscale scores on the Eating Disorders Inventory were also associated with ideation and attempts drive for thinness and body dissatisfaction.

Medical Diseases

Keiser, et al. (2010) found a suicide rate of 158 per 100,000 per year in Switzerland for patients with HIV compared to 19 for the general population. Suicide rates were higher in older patients, men, injection drug users, and patients with advanced clinical stage of HIV illness but lower if there was an increase in CD4 cell counts.

Espinosa, et al. (2010) found that attempted suicide in possibly psychiatric patients with epilepsy was predicted by a family history of psychiatric disorder, current major depression, poor performance on the Wisconsin Card Sorting Test (perseverative responses and total errors) and left temporal lobe epilepsy, but not impulsivity or disease duration.

Stefanello, et al. (2010a) compared people with epilepsy with controls and found that the epileptics scored higher for depression, anxiety and lifetime suicidal ideation and attempted suicide. Stefanello, et al. (2010b) found a high incidence of suicidal ideation and attempts in a sample of patients with epilepsy, and suicidal ideation was associated with anxiety, depression and two or more psychiatric disorders.

In a follow-up study of patients with severe acne and who were treated with isotretinoin, Sundström, et al. (2010) found that that severe acne, regardless of exposure to isotretinoin, carries an increased risk of attempted suicide (and it seems to me completed suicide also, but they do not mention this).

Roy, et al. (2010) studied African Americans with and without Type 1 diabetes. Those with diabetes were more likely to have attempted suicide. For the diabetics, the attempted suicides were more likely to be female, depressed and hostile, and to report a history of childhood trauma, smoking, alcohol abuse, and

drug abuse. For these patients, suicidal ideation was associated with depression, hostility and childhood trauma.

In a large American national sample, Messias, et al. (2010) found a positive association between a history of seasonal allergies and a history of suicidal ideation but not for a history of suicide attempts.

Breshears, et al. (2010) found that a Suicide Potential Index and a Suicide Ideation Scale taken from the Personality Assessment Inventory predicted suicidal behavior in the two years after assessment in a sample of veterans with traumatic brain injury, a useful finding for clinicians but of no use for understanding suicide.

In a national survey, Mota, et al. (2010b) found that abortion was associated with a higher incidence of suicidal ideation and attempts, as well as, psychiatric disorders such as anxiety and depressive disorders.

Prisoners

In a large sample of Italian male prisoners, Carli, et al. (2010) divided them into two groups based on an impulsivity scale of high and low impulsivity. The two groups did not differ in attempted suicide, but the group with high impulsivity more often had suicidal ideation (but not in a multiple regression with other variables).

In a study of inmates in the American juvenile justice system, Wasserman, et al. (2010) found that lifetime and past month attempted suicide were associated with being female, white, and in detention or secure facilities versus system intake, as well as psychiatric diagnosis and substance abuse.

In English male prisoners, Rivlin, et al. (2010) found that those who attempted suicide more often had a psychiatric disorder (major depression, psychosis, anxiety disorder and substance abuse disorder) and more often had comorbidity.

In a study of female prisoners (in prison or a substance abuse facility), Kimonis, et al. (2010) examined 17 predictor variables and found that attempted suicide was associated with childhood abuse, psychopathy, and both internalizing and externalizing symptoms.

In a sample of Canadian male prisoners, Naud and Daigle (2010) found that the scores of those with suicidal behaviors (attempts or ideation) scored higher on subscales to measure hopelessness, negative self-evaluation and hostility, but did not predict subsequent completed suicide.

In a study of Swedish prisoners (plus those on remand and probation), Hakansson, et al. (2010) found that attempted suicides more often reported binge drinking, intake of illicit drugs, injection of drugs, physical and mental illness, problematic family history, and a history of being abused.

Studies of Suicidal Ideation

Methodological Issues

Maltsberger, et al. (2010) noted that, for some people, suicidal ideation (daydreaming) may inhibit suicidal action.

Youths

In Estonian adolescents aged 13-15, Heidmets, et al. (2010) found that suicidal ideation (and other symptoms) were associated with loss of virginity, especially if at age <13.

In a study of middle and high school students in South Korea, Park, et al. (2010e) found that suicidal ideation was associated with anger suppression, entrapment, psychosomatic symptoms and depression but not with resilience (although resilience played a role in the multivariate analyses). In a sample of South Korean adolescents, Park, et al. (2010c) found that suicidal ideation was associated with state anger, trait anger, anger-in, anger-out and anger control.

In a large study of American youths in grades 7 to 12, Gangwisch, et al. (2010) found that suicidal ideation was less frequent in those whose parents set bedtimes at < 10pm than in those who set bedtimes as > midnight

In a study of 17-year-olds, Pranjić and Bajraktarević (2010) found that suicidal ideation was associated with being a victim in relationships, a victim of bullying and being a bully.

Samm, et al. (2010) found that suicidal ideation in 11-15 year-old adolescents was associated with female, younger age, bad relationships with family members (parents, siblings and grandparents), and having a step-parent.

In a sample of 15-18-year-old South Koreans, An, et al. (2010a) found that suicidal ideation was associated with female gender, insufficient sleep, dissatisfaction with one's health, dissatisfaction with family and with maternal reports of insufficient sleep and, for both parents, a history of suicidal ideation and dissatisfaction with their family.

In Brazil, de Mattos Souza, et al. (2010) found that suicidal ideation in youths aged 11-15 was associated with female gender, current alcohol consumption, use of illicit drugs, symptoms indicating conduct disorders and high depression scores.

In a sample of university students, Wilson, and Deane (2010) found that suicidal ideation was associated with lower help-seeking intentions for family, friends, and professional mental health care, and higher intentions to seek help, as well as depression, anxiety and hopelessness.

In a poorly presented study (the authors say that they removed the question on suicide planning from the questionnaire!), Baggio and Palazzo (2009) found that 12-18 year-old Brazilian adolescents who had planned suicide were more often girls and those who reported problems in the relationships with their parents, drug use by friends, having a small number of close friends, being bullied by classmates and who reported feelings of loneliness or sadness.

In a sample of youths aged 11-20 see in primary care, Gardner, et al. (2010) found that suicidal ideation was more common among girls, younger youths, substance users, depressed youths, youths who carried weapons, those who had been in fights and those who reported at least one other serious behavioral health problem.

In a national survey of American teenagers (14-19), Hockenberry, et al. (2010) found that suicidal ideation was more common in teenagers who smoke but whose parents do not smoke, but not more common in those whose parents smoked regardless of whether the teenager smoked. Suicidal ideation was also associated with depression.

Van Leeuwen, et al. (2010) studied French high school students who were second generation immigrants. Suicidal ideation was associated positively with stressful life events, depressive symptoms, and individualism and negatively with attachment to parents. For the girls, borderline traits (positively), assimilation and marginalization (negatively) predicted suicidal ideation.

In adolescents aged 15-19 in primary care, Hardt and Johnson (2010) found that suicidal ideation was association with depression and the past month experience of minor negative life events but not with major negative life events. (The table of correlations in the paper is incorrectly formatted.)

For adolescents in grades 6-8, Heilbron and Prinstein (2010) found that increases over time in suicidal ideation was associated with overt victimization for girls (but not for boys) while relational victimization (gossip and rumor) was not associated with ideation for boys or girls. Low levels of preference-based popularity were associated with increases in suicidal ideation over time.

Bonanno and Hymel (2010) studied students in grades 8-10 and found that suicidal ideation was associated with victimization by bullying, general and social hopelessness and support from family and friends.

For adolescents in grades 7-12 in Hong Kong, Ng, et al. (2010) found that suicidal ideation was associated positively with being female, lack of confidence, conduct disorder, and emotional symptoms and negatively with spirituality (tranquility and resilience) and in a higher grade level.

Lai Kwok and Shek (2010a) found that suicidal ideation in adolescents in Hong Kong was associated positively with hopelessness and negatively with good parent-adolescent communication, especially mother-adolescent communication. Lai Kwok, et al. (2010b) found that suicidal ideation in this group was associated with hopelessness but negatively related to emotional competence, social problem solving, father-adolescent communication, mother-adolescent communication and family functioning, but most strongly with hopelessness.

In a study of school children (aged 6-13) from low income families, Cicchetti, et al. (2010) found that suicidal ideation was associated with maltreatment, with more types of maltreatment associated with a higher suicidal ideation score.

Yu, et al. (2010) compared high school students one month before and one month after the earthquake in Sichuan, China by using self report one month *after* the earthquake. For those reporting prior suicidal ideation, being female, perceived sense of security obtained from teachers and exposure to encouraging news reports were associated with reduced suicidal ideation, whereas pre-earthquake corporal punishment and worry about severe earthquakes in the future increased the incidence of suicidal ideation.

Cho and Haslam (2010) samples of South Korean-born high school students in America living with both parents (and intending to stay in America), South Korean students living with one or neither parent and intending to return to South Korean, South Korean students in South Korea, and American students. Their presentation of the results is poor since they failed to report the correlations and regression for each group. The immigrant group had the lowest suicidal ideation scores and the temporary staying group the highest scores. For the temporary staying group, suicidal ideation was associated with positively with acculturative stress and life stress, and negatively with living with both parents and parental support.

In a poorly designed study, Thompson, et al. (2010) combined various samples of children who had been maltreated, who were at risk of maltreatment and who were neither. They found that suicidal ideation was associated with maltreatment and exposure to violence.

Adults

In a sample of general medical patients in Kenya, Ndetel, et al. (2010) found that suicidal ideation was associated with a younger age and depression scores.

In Sri Lanka, Samaraweera, et al. (2010) found that suicidal ideation was associated with younger age, physical illness and higher levels of helplessness and hopelessness.

In a sample of university students, Taylor, et al. (2010c) found that suicidal ideation was associated with defeat, entrapment, hopelessness, problem-solving appraisal and low social support.

De Groot, et al. (2010) found that suicidal ideation in those who lost a spouse or first-degree relative to suicide was associated with depression, anxiety, a prior suicide attempt, lower self-esteem and less of a sense of self-control.

In older adults in the community (aged 60-95), Marty, et al. (2010) found that suicidal ideation was positively associated with dysfunctional coping styles and negatively associated with problem-focused and emotion-focused problem solving styles and with reasons for living.

Cheng, et al. (2010) found that lifetime suicidal ideation and attempts in a large sample of American Asians were positively associated with female gender, family conflict, perceived discrimination, and lifetime depressive or anxiety disorders, but negatively associated with a high level of identification with one's ethnic group. For Asian men only the presence of chronic medical conditions was associated with suicidal ideation.

In a large survey of older (>55) Canadian adults, Corna, et al. (2010) found that suicidal ideation was associated with being male, younger and widowed, and reporting lower social support and higher psychological distress.

In American veterans of foreign wars, Pietrzak, et al. (2010) found that suicidal ideation was associated with PTSD, depression and alcohol problems, and higher scores on measures of psychosocial difficulties, stigma, and barriers to care, and lower on measures of resilience and social support.

In a sample of junior enlisted active duty airmen, Bryan, et al. (2010b) found that scores on the Suicide Behaviors Questionnaire were associated with negative affect, perceived burdensomeness, and thwarted belonging as predicted by Joiner's Interpersonal Theory of Suicide.

In a sample of female college students, Lamis, et al. (2010) found that suicide proneness (!) was associated with partner psychological abuse and alcohol-related problems.

In a survey in Baltimore (USA), Clarke, et al. (2010) found that suicidal ideation was most common in current smokers, then former smokers and least in non-smokers, and also in females and in those with depressive disorders.

In a four-year follow-up of college freshmen, Wilcox, et al. (2010) found that persistent suicidal ideation was predicted by low social support, childhood or adolescent exposure to domestic violence, maternal depression, and higher levels of depression but were no more likely than one-time ideators to have made a suicide plan or attempt during college.

Osman, et al. (2010) developed a Suicide Anger Expression Inventory to evaluate suicide rumination, maladaptive expression (i.e., anger directed at others or situations), reactive distress (negative beliefs about the circumstances and consequences of an interpersonal anger-related event [i.e., internalized anger]), and adaptive expression (the ability to focus positively on resolving real-life problems in affect-arousing [i.e., anger] situations). Suicide rumination and reactive distress predicted scores on the Suicide Behavior Questionnaire.

In a study of American medical students, Schwenk, et al. (2010) claimed that suicidal ideation was more common in 3rd and 4th year students, but the data analysis was poor and limited.

In Indian female undergraduate students, Chatterjee and Basu (2010) found that reasons for living was negatively associated with suicidal ideation.

In study of elderly patients in primary care in one county in the state of New York, Cohen, et al. (2010a) found that residents in poorer census tracts more often had suicidal ideation, and adjusting for personal demographic and clinical variables did not eliminate this association.

In a sample of Mexican or Mexican-American women who were primary care outpatients, Garza and Pettit (2010) found that perceived burdensomeness and depression, but not familism (family inter-connectedness and family honor) or responsibility to family predicted suicidal ideation.

Pereira, et al. (2010) found that psychache, depression and hopelessness were associated with suicidal ideation in both male and female undergraduates and in male prisoners. In regression, only psychache was a predictor of suicidal ideation.

In a study of American veterans from the Iraq and Afghanistan wars seeking mental health treatment, Jakupcak, et al. (2010) found that suicidal ideation was lower in those who were married, satisfied with their social networks, and without PTSD.

In Chinese undergraduate students in Hong Kong, Lam, et al. (2010) found that suicidal ideation was associated with the social axiom dimensions of social cynicism, reward for application, and social complexity and, in a second study, also to negative life events and neuroticism (from the Big 5).

In a sample of Australian adults, Roeger, et al. (2010) found that the experience of being bullied at school predicted adult suicidal ideation even after controls for depression and socio-demographic variables.

For young and middle-aged adults in South Korea, Park, et al. (2010a) found that suicidal ideation was associated with lack of social support. They concluded:

> Poor emotional support significantly influenced suicidal ideation in middle-aged men, whereas lack of instrumental support significantly affected suicidal thoughts in middle-aged women, after controlling for sociodemographic factors, health behaviors, and health status. High alcohol use, functional limitations, and stress were related to suicidal thoughts in young adults, whereas depressive feelings had the strongest association with suicidal ideation in middle-aged women. (p. 389)

In a follow-up study of callers to a telephone crisis center, Witte, et al. (2010) found that a scale to measure plans and preparations and suicidal ideation did not predict suicidal ideation or attempt at follow up 1-48 days later.

In a study of German adults aged 35-74, Michal, et al. (2010) found that suicidal ideation was associated with female sex, living without a partner, low socioeconomic status, diagnosis of coronary heart disease, family history of myocardial infarction, smoking and mental distress, as well as age, self-reported depression, panic disorder, depersonalization, Type-D personality (the joint tendencies of negative affectivity and social inhibition) and impairment by mental distress.

Johnson, et al. (2010c) studied suicidal ideation in college students and found that suicidal ideation was associated negatively with positive self-appraisal and reasons for living, but not with stressful life events, emotion regulation or broadminded coping.

In a sample of German adults, Ladwig, et al. (2010) found that suicidal ideation was associated with anxiety and a high level of somatic complaints, particularly dyspnea, a depressive syndrome and impaired self-perceived health and, for men, unemployment and living alone.

In a sample of elderly people in residential care, Malfent, et al. (2010) found that suicidal ideation was negatively associated with internal locus of control, self-

efficacy and satisfaction with life and positively with depression and being in psychotherapy.

In an Indian sample, Manohar and Kannappan (2010) found that the wives of alcoholics, as compared to the wives on non-alcoholics, had more suicidal ideation and had suffered more physical abuse (but not more sexual abuse).

In a sample of French adults aged18-30, Legleye, et al. (2010) found that suicidal ideation was associated for men with depression, homosexual intercourse, absence of sexual activity, living alone, daily tobacco smoking, being unemployed, serious health event concerning the father, age 26–30 and bad relationships between parents. For women, suicidal ideation was associated with depression, lifetime experience of forced sexual intercourse, having consumed illicit drugs other than cannabis, living alone, being unemployed, bad relationships between parents and age 26–30.

In an online survey, Harris, et al. (2010) found that engaging in an internal debate about whether to die by suicide or not was associated with depression, the wish to die and searching online for reasons for living and for dying. Scores on the Suicide Behaviors Questionnaire had similar correlates.

Davidson, et al. (2010) studied African-American college students, and, in a poorly presented study seem to have found that suicidal ideation was associated with some scales of a measure of trait hope (pathways, but not agency or goals) and with perceived burdensomeness and thwarted belonging (but not the acquired capability for self-harm).

In a survey of residents of Washington state (USA), Calder, et al. (2010) found that suicidal ideation was associated with both childhood and adult experience of both physical and sexual abuse even after controlling for age, gender, income, education, race, employment and marital status.

Kõlves, et al. (2010) studied recently separated people (<18 months) in counseling. The men more often developed suicidal ideation than the women. Suicidal ideation overall was associated with mental health problems (during the previous year), a history of suicide attempts and internalized shame. For males, the predictors also included lower education, separation-related shame and stress from legal negotiations, especially about property/financial issues.

Patients with Psychopathology

In a sample of emergency psychiatric patients, Penagaluri, et al. (2010) found that those with non-psychotic hallucinations experienced greater intensity of suicidal ideation versus those with no hallucinations or those with psychotic hallucinations.

Affective Disorder

In a sample of patients with major depression and insomnia, McCall, et al. (2010) found that suicidal ideation was associated with higher levels of insomnia, depression but not with anhedonia.

Selvi, et al. (2010) found that, for both patients with major depression and healthy controls, suicidal ideation was associated with being an evening rather than a morning person, depression score and sleep quality.

In a sample of affective disorder outpatients, Vázquez, et al. (2010b) found no differences in suicidal ideation between bipolar-I and bipolar-II patients, but suicidal ideation was less common in patients with bipolar subtype IV (with hyperthymic temperament) compared with bipolar-NOS patients.

In a sample of patients with major depression who smoked and who were in a program to stop smoking, Berlin, et al. (2010) found that those who abstained successfully had less suicidal ideation than those who failed to quit.

In a sample of patients in primary care with major depression, Gensichen, et al. (2010) found that suicidal ideation was associated with male sex and the severity of depression, and negatively with absence of pain and older age.

In a sample of patients with major depressive disorders, Morris, et al. (2010) found that suicidal ideation was associated with social phobia, bulimia nervosa, number of past depressive episodes, and being white (versus black).

Harrison, et al. (2010) found that suicidal depressed elderly (>60) reported the lowest levels of perceived social support (belonging, tangible support, and self-esteem) and higher levels of chronic interpersonal difficulties (struggle against others and interpersonal hostility), compared to non-suicidal depressed and non-depressed elderly.

Psychosis

In patients with first episode psychosis, Barrett, et al. (2010a) found that suicidal ideation was associated with depressive symptoms, having a schizophrenia spectrum disorder, insight, and beliefs about negative outcomes for psychosis.

In a sample of patients with schizophrenia-spectrum disorders, Johnson, et al. (2010b) found that suicidal ideation was associated positively with hopelessness and negatively with positive self-appraisal.

In a sample of patients with schizophrenic spectrum disorder, Taylor, et al. (2010b) found that suicidal ideation was predicted by defeat and entrapment even after controlling for hopelessness and depression, as well as the positive symptoms of suspiciousness and hallucinations.

Schennach-Wolff, et al. (2010) found that suicidal patients (undefined) with schizophrenic spectrum disorders scored higher on the PANSS negative subscore, PANSS insight item and depression total score at admission and at discharge than non-suicidal patients.

Obsessive-Compulsive Disorder

In a sample of obsessive-compulsive outpatients, Hung, et al. (2010) found that a higher score on a scale to measure the severity of the disorder was associated with suicidal ideation, anxiety and depression. However, in a multiple regression, only anxiety and depression scores predicted suicidal ideation.

Balci and Sevincok (2010) found that major depression and aggressive obsessions, the level of hopelessness, and the severity of obsessive-compulsive symptomatology predicted suicidal ideation in patients with obsessive-compulsive disorder.

Panic Disorder

Huang, et al. (2010) found that suicidal ideation in patients with panic disorder was associated with younger age, current alcohol use, more severe panic symptoms, and less social support, but not with agoraphobia.

Addiction

Conrad, et al. (2010) studied a sample of patients entering treatment for alcohol or drug addiction. They defined an atypical pattern of suicidal ideation as having no or low depression. They claimed that atypical group scored higher on suicidal ideation and lower on symptoms of internalizing disorders, and similarly or lower on substance problems, symptoms of externalizing disorders, and crime and violence.

Prisoners

Zhang, et al. (2010) found that suicidal ideation in Chinese prisoners (male and female) was associated with self-esteem, depression and social support and, for men, childhood maltreatment. Similar results were found for adolescent offenders and police cadets.

Medical Diseases

In a sample of patients with amyotrophic lateral sclerosis (ALS), Palmieri, et al. (2010) found that suicidal ideation was more common in recently diagnosed patients and that ALS patients more often had suicidal ideation than patients with myasthenia gravis (a neuromuscular autoimmune disorder which is usually not fatal).

In a sample of patients with traumatic brain injury, Wood, et al. (2010) found that suicidal ideation was associated with alexithymia and depression (especially the component of worthlessness).

In a sample of patients with end-stage renal disease on hemodialysis, Chen, et al. (2010b) found that suicidal ideation was association with depression, anxiety, fatigue and poor quality of life.

In a sample of patients with HIV in rural China, Lau, et al. (2010) found that suicidal ideation was associated with physical functioning, depression score and their spouse's depression score.

In a study of patients admitted for medical or surgical reasons, Botega, et al. (2010) found that suicidal ideation was most frequent in infectious disease, oncology and hematology units and associated in general with depression, younger age, alcohol abuse, use of psychotropic medicine and smoking.

Akechi, et al. (2010) studied patients with cancer and major depression. Suicidal ideation was associated with poor physical functioning and an advanced stage (but not pain) for male patients, but not for female patients.

Prisoners

In a sample of Chinese prisoners, Zhang, et al. (2010e) found that suicidal ideation was positively associated in male prisoners with smoking, term served, childhood abuse and depression and negatively with social support and alcohol use. For female prisoners, suicidal ideation was positively associated with drinking alcohol, the length of sentence, the number of imprisonments, and negatively with self-esteem and social support.

Peng, et al. (2010) found that suicidal ideation in male prisoners in Taiwan with HIV was predicted by recent psychological distress and lifetime experience of depression for two weeks or more, serious anxiety or tension, and hallucinations.

In a sample of adolescents in custody, Woolgar and Tranah (2010) found that inducing a negative mood (through music and thoughts) had an impact on a negative self-evaluation only for those with suicidal ideation.

The Language of Suicide

Heilbron, et al. (2010) criticized the use of the term *suicide gesture* with its dismissive connotation and suggested alternatives. I would suggest that the use of the word *attempt* with the serious of the intent noted is an obvious alternative.

Discussion

Personal Comments

I am shocked to find in the year 2010 a paper showing that attempted suicide predicts later completed suicide and another that reasons for living is negatively associated with suicidal ideation. I wonder what happens if I let go of my pencil. Will it fall to the ground? Research into topic in suicidology often seem simple and repetitious of well-know results.

There is often a failure to distinguish between ideation and attempts which detracts from the usefulness of the research and there are far too often incomprehensible statistics

What Have We Learned About Suicide?

Often during my reviews of the suicide research each year from 1998 through 2010, I have criticized the research that is done. Hjelmeland and Knizek (2010) have made similar criticisms, arguing that only qualitative research can further our *understanding* of suicidal behavior.

There was not much new found in this review, except for studies on the impact of the parents' ages at the birth of the subjects, the month of birth and the first study that I know of changes in suicide by era.

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