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Shawna Burrow

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An Overview of Suicide and the Impact of Interacting Factors on Current Suicide Trends

Shawna Burrow

East Tennessee State University

Midway Honors College

Abstract

Approximately 44,965 people committed suicide in 2016 in the United States, and the rate has been rising for a decade and a half. Suicide has far-reaching consequences which affect not only the victim, but those close to the person as well. For every suicide, an estimated six people are further traumatized, bringing the current loss survivor estimate to over 5 million. Additionally, suicide costs tax payers about 70 billion dollars annually. Despite outranking homicide as a leading cause of death, the long-standing stigma associated with suicide creates a barrier for open and effective communication about the issue. This paper investigates the changing attitudes about suicide across time, the impact of the interacting factors of gender, age, sexuality, and depression, current suicide myths, the trend of suicide by cop, and discusses future needs for research and effective intervention and prevention.

An Overview of Suicide and the Impact of Interacting Factors on Current Suicide Trends

According to the American Association of Suicidology [AAS], every 12 minutes in the United States someone commits suicide (2015). Currently, suicide is the tenth leading cause of death for adults in the U.S. and the second leading cause death among young people (American Foundation of Suicide Prevention [AFSP], 2015). The Centers for Disease Control [CDC] defines suicide as death caused by self-directed injury with an intent on dying (2017). Suicide is not a new issue, however. In fact, early records of suicide can be traced all the way back to antiquity. For as long as people have been living, they have experienced stress, tragedies, and heartbreak which has led to suicide for many.

Suicide History

While the occurrence of suicide has remained steady across history, attitudes towards it have fluctuated over the centuries and across cultures. The ancient Greeks, who are known for their consideration of ethics, and the sanctity of life, generally frowned upon suicide. Many saw it as a cowardly act and against the will of the gods. Philosophers of the day, Aristotle and Plato, scrutinized suicide through the lens of the law rather than morals, arguing that it should be considered a crime (Papadimitriou et al., 2007). However, despite their harsh indictment, both Plato and Aristotle also made concessions for suicide under certain circumstances. They endorsed suicide if it was justified by order of the government (as punishment), in response to an incurable illness, or in the face of an intolerable misfortune (Society for Old Age Rational Suicide [SOARS], 2015). Plato also suggested that suicide was preferable for those who were unable to control their criminal behavior (Papadimitriou, 2007).

The democratic people of ancient Rome took a more lenient approach towards suicide, viewing it more as an individual right. Ending one's life was a supported idea in several

situations. Like the Greeks, Romans felt suicide was a welcome alternative to living with a debilitating illness or when befallen by a great misfortune such as the death of a loved one. Honor and status were supremely important concepts in ancient Rome. Therefore, “saving-face” was also considered a valid reason for suicide as it helped the person avoid dishonor (SOARS). Interestingly, Romans were expected to gain permission from the government before acting. The person wishing to commit suicide would apply to the Senate for authorization. The Senate would then judge the person’s reason(s) and if the motives were found to be sound, the suicide would be sanctioned and poisonous Hemlock would even be provided (Valijak, 2017).

The Middle Ages, ushered in a sharp shift in attitudes concerning suicide. The Catholic Church declared suicide an affront to God and a grave immoral sin which could not be forgiven (Ferngren, 1989). The British crown followed suit by naming it a serious crime. One may ask how a dead person can be further punished. Those unfortunates who committed suicide were subject to great humiliation of their bodies. They were often drug through the streets, publically hung, and denied a Christian funeral or burial in hallowed ground (SOARS). Since superstitions ran high, the bodies would routinely be buried at a crossroads with a stake driven through their chest in order to keep restless spirits from wandering (Ferngren, 1989). Due to the aftermath, most people went to great lengths to conceal suicide in an effort to avoid the painful fall-out on their families. The crown responded by employing coroners, who were charged with investigating any suspicious deaths. Coroners presented their findings to a jury of the deceased peers, who had to officially confirm the mode of death (Seabourne & Seabourne, 2001). This was an important process as any person found to have committed suicide, in addition to the above mentioned consequences, would also have all their possessions confiscated by the royal authorities (Seabourne & Seabourne, 2001).

The more enlightened Renaissance period brought about opposition to these dogmatic views against suicide, favoring a more “modern” attitude. Rather than being a crime against God and nature, suicide was again considered a matter of personal choice (Ferngren, 1989). Free-will meant your life is your own and therefore choosing to end it should carry no disgrace or blame. Like their Greek and Roman counterparts, Renaissance philosophers, especially supported suicide as an alternative to a painful incurable illness (Soars). Michel de Montaigne (1877), wrote in his famous essays, “Unendurable pain and fear of a worse death seem the most excusable motives for suicide” (p 48). Many during the Enlightenment offered counterarguments to the Church’s position that suicide was an unforgiveable sin. Philosopher, David Hume, wrote much about suicide, ultimately arguing in his 1777 *Of Suicide Essay* that, “Suicide is no transgression of our duty to God” (p. 580). His reasoning was grounded in the notion that our death is inevitable regardless of the instrument (Hume, 1777).

Despite the ambiguity of feelings which has carried over to the present day, suicide is a taboo subject that is largely undiscussed in polite conversation. However, it has continued to be the focus of steady research since the late 1930s (SOARS). We cannot ignore that suicide is a serious health issue which claims the lives of approximately 44,000 Americans each year and carries a price tag of 70 billion annually (AFSP).

Gender and Suicide

Statistically, white men over 45 are at the highest risk as they account for seven out of every 10 suicides (AAS). The National Institute of Mental Health [NIMH] report that men are four times more likely to die from suicide than women (2015). However, women actually attempt suicide twice as much as men (AFSP). Little research has focused on how gender differences impact suicidal behavior. Historically, women who attempt suicide are more likely to

be stigmatized and labeled as manipulative or attention-seeking and their suicidal behavior not taken as a serious attempt at dying (Vijayakumar, 2015).

However, current research suggests that gender does play a role in the risk of suicide as women are twice as likely to become depressed as men and depression is the most common risk factor for suicide (Vijayakumar, 2015). There are several gender specific issues that increase vulnerability and place women at a higher risk of suicide such as: eating disorders, fertility problems, abortion, abuse, domestic violence, and hormonal imbalances (Vijayakumar, 2015). Women who experience postpartum psychosis have a seven fold increase in suicide risk in the first year following delivery and a 17 times greater risk in the future. Menstrual cycle issues are another important risk factor for women, with an estimated 25 percent of female suicides happening during menstruation and more suicide attempts occurring during the lowest serotonin and estrogen cycle phases (Vijayakumar, 2015).

Perhaps the biggest contrast contributing to the differences in suicide deaths among men and women over time is their choice of method. Historically, men have chosen more lethal means of self-harm. The World Health Organization [WHO] reports that men prefer firearms and hanging, while women premodinately use poision or drowning as their weapon of choice (2015). Guns are the fastest growing method of suicide and their use in suicide now outnumber homicides (CDC). In fact, two-thirds of all deaths involving guns in America are suicides (Rhodan, 2017), and more than half of all suicides (51%) are completed using firearms. Approximately 80 percent of all gun-related suicides are men. The second leading method of choice among men is hanging which accounts for approximately 26 percent of all suicide deaths (AAS). Suffocation as the method of choice has risen about 26 percent in both men and women over the last decade (Alter, 2016). Poisoning is the third most popular and used about 15 percent

of the time (CDC). Poisoning, mostly via prescription drug overdose, also happens to be the leading choice among women (AAS).

The total suicide rate has spiked 24 percent over the past 15 years but has increased more for women than men (NIMH). In fact, the age-adjusted rate augmented in women by 45 percent compared to only 16 percent for men (Alter, 2016). All female age groups have experienced a rise in suicide, with middle-aged women (45-64 yrs.) seeing the biggest hike (Alter, 2016). The upsurge trend in suicide has also had a great impact on the young female group with suicides of 10 to 14 year old girls tripling over the past 15 years (Bichell, 2016). Also, among adolescence girls aged 15 to 19 years, suicide is currently the leading cause of death (Vijayakumar, 2015).

Age and Suicide

Suicide affects people of all ages. However, people age 65 or older are traditionally the highest risk group, especially men. Older men have a suicide rate of 17 per 100,000 per year, which is much higher than the overall rate of 13.9 per 100,000 (AAS). Every 64 minutes in America an older person commits suicide, accounting for approximately 18 percent of all suicides or about 8,200 of the total 44,965 suicide deaths. It is important to note that older adults actually attempt suicide less than other age groups, but have a higher completion rate than all ages combined (AFSP). Older individuals complete suicide an estimated one out of every four attempts, compared to one completion per 100-200 attempts across all other groups (AFSP). Their higher completion rates are likely linked to the preferred use of firearms as a method as older adults use guns about 72 percent of the time (AAS).

The prosperity and better healthcare practices of the baby boom generation, has made the “oldest old” age group (85 and older) the fastest growing elderly population. According to the National Institute of Health [NIH], the “oldest old” group is projected to grow to about 19

million by 2050, which is an exponential hike from the three million in 1994 (2016). White men in this category have a suicide rate nearly two and half times larger than men in any other age group at about 50 per 100,000 (AAS). Elderly men have a suicide rate that is five times greater than elderly women and account for 84 percent of all elderly suicides (AFSP). Older age is linked to several high risk factors which increase vulnerability including: an increased risk of untreated depression, chronic illness, uncontrolled pain, the deaths of loved ones, social isolation, loneliness, and higher rates of alcohol and substance abuse (AAS).

Suicide is the second leading cause of death among children (10 -14 yrs) and adolescents aged 15 to 24 years (AAS). While children and adolescents are perceived as unlikely groups for increased suicide risk, only accidents cause more deaths in these age groups (CDC). Suicide is a serious issue for young people. Amongst these two groups, one young person dies every hour and twenty-five minutes (AFSP). Young boys are four times more likely to commit suicide than young girls (AAS). About 18 percent of high school students admit to seriously considering suicide, 15 percent have actively made a plan, and nearly nine percent attempt suicide at least once (Kaslow, 2014). Firearms are the most popular method among young people and are used about 45 percent of the time and hanging is a close second, accounting for approximately 40 percent (Kaslow, 2014).

Recognizing a suicidal young person can be difficult because depression in teens and children looks different compared to adults. Instead of sadness, they often appear angry or rebellious (Mayo, 2018). Since these behaviors are stereotypically associated with youth, we commonly overlook them as a serious indication of depression or suicidal thinking. Depression often goes overlooked in very young children as well. Compounding the problem is the fact that children under the age of 10 lack an understanding of the finality and irreversibility of death

(Graham, 2013). This understanding gap and their tendency towards impulsiveness places very young children at an increased risk of “unintentional” suicide (NIMH). They may engage in self-harming behavior without full comprehension of the consequence of death.

Young people have unique suicide risk factors which differ from adults. These factors can be intrapersonal, social, or cultural in nature (Kaslow, 2014). Intrapersonal factors include a recent loss or trauma, a low sense of self-worth or self-esteem, discipline problems, and engaging in high-risk behaviors (Kaslow, 2014). Socially speaking, a family history of suicide or violence, abuse or neglect, a lack of support, and being a victim of bullying or being a bully increase risk of suicide in teens and children (Kaslow, 2014). Finally, on a cultural level, risk factors include: easy access to guns, the stigma of asking for help, limited access to preventative services, and moral or religious beliefs (Kaslow, 2014).

Sexuality and Suicide

Experiences of victimization are linked to a proliferation of suicidal ideation. Sexual orientation has emerged as an increased source of victimization and stigma among Lesbian, Gay, Bisexual, and Transgender [LGBT] youth (Russell & Joyner, 2001). They are much more likely to suffer from “Minority Stress” (Tracy, 2016) and related incidences of bullying, teasing, harassment and physical assault (CDC). The 2015 National Youth Risk Behavior Survey reports that 34 percent of LGBT youth are bullied at school, 28 percent experience cyberbullying, 23 percent experience sexual dating violence, and 18 percent have been forced to have intercourse at some point. Sadly, one in seven report having experienced a physical assault (Tracy, 2016). Such victimization puts LGBT youth at an intensified risk of depression, substance abuse, feelings of hopelessness, and social isolation, which in turn heightens their risk of suicidal thoughts and attempts (Tracy, 2016).

Another unique risk factor concerning the LGBT youth population is rejection. Studies report that those rejected by their family for their sexual orientation are eight times more likely to attempt suicide (Tracy, 2016). Hopelessness plays a large role among LGBT suicide with 60 percent reporting feeling sad or hopeless every day for two or more weeks compared to only 26 percent of their heterosexual counterparts (AAS). Approximately 43 percent of LGBT youth admit having seriously considered suicide with 38 percent actually making a plan and 29 percent following through with an attempt (AAS). These statistics suggest that adolescent stressors may be amplified by difficulties associated with dealing with sexual identity. Indeed, LGBT youth attempt suicide three times more often than their heterosexual peers (Tracy, 2016).

Depression and Suicide

Depression is the most common mental illness associated with suicide (Peebles, 2011). Depression is a major issue which affects 350 million people worldwide (NIMH) and 25 million Americans annually (AFSP). An estimated two-thirds of all people who commit suicide are depressed at the time of the act (NIMH). Untreated depression raises the lifetime risk of suicide by 20 times (AFSP). Statistics reveal that for every 100 people diagnosed with depression, seven men and one women will go on to complete suicide (CDC). Knowing and recognizing the symptoms of depression can ultimately help in preventing suicide. The most common signs of depression are feelings of sadness, tearfulness, outbursts of anger or frustration, a loss of pleasure in activities, sleep disturbance, loss of energy, and slowed movement or thinking (Mayo, 2018).

Suicide by Cop

A new form of suicide has emerged as a recent trend called suicide by cop or SBC. The Federal Bureau of Investigation defines suicide by cop as a situation whereby an individual

intent on dying engages in consciously life-threatening behavior meant to compel a police officer to respond with deadly force (Salvatore, 2014). Suicide by cop is divided into three categories: direct confrontation, disturbed intervention, and criminal intervention (AAS). Of the three types, only direct confrontation is linked with pre-planning (Salvatore, 2014). In this scenario, individuals attack law enforcement for the explicit purpose of being killed. These attacks can include: manipulated assaults, controlled attacks, and direct Kamikaze or blitz attacks. Statistics report direct confrontations account for about 16 percent of suicide by cop deaths (Salvatore, 2014).

Disturbed Interventions are more common at about 20 percent (AAS). These include circumstances where the police respond to intervention calls where an emotionally disturbed person needs help. Often, these calls involve individuals suffering from mental illness, intoxication, or domestic problems (AAS). When a person involved in criminal activity prefers death to arrest, it is categorized under the criminal intervention type. No clear evidence of pre-planning is discerned on cases involving disturbed or criminal intervention, but rather the individual makes the decision under the emotional strain of that moment (AAS).

Statistical analysis indicates that nearly 95 percent of suicide by cop victims are male and 45 percent of those are white. More than half (54 %) of the men are unemployed and 29 percent are homeless at the time. The average median age of male victims is 35. Five percent of SBC victims are females with an average age of 40. Mental illness plays a large role in Suicide by cop risk, with approximately 62 percent of the men and 100 percent of women suffering from a documented mental illness. Of all suicide by cop cases, 80 percent of the men and all (100%) of the women were armed. The triggers or risk factors most associated with SBC are feelings of

being trapped, ashamed, hopeless, desperate, or revengeful. SBC victim's behavior is often attributed to "saving-face" or an attempt to evade moral responsibility (AAS).

Suicide Myths

The stigma of suicide is exaggerated by several long-standing myths. These myths often block communication about suicide and hinder prevention. One important myth argues that people who threaten suicide are not really serious, but rather just seeking attention (Division of Public and Behavioral Health [DPBH], 2017). However, an attempt or threat of suicide should never be ignored as statistics show that about 70 percent of those who threaten suicide end up making an attempt or actually complete suicide (AFSP). It is important to remember that if they are seeking attention, then attention is obviously needed and should be given. A second suicide myth contends that only certain types of people are suicidal. However, the truth is that anyone can commit suicide (Tennessee Suicide Prevention Network [TSPN], 2018).

Another important myth reasons that suicide happens without any warning. The truth, however, is that the majority do show signs (DPBH). In fact, research suggests that eight out of ten suicide victims display some type of warning behaviors (TSPN). Becoming aware of the possible warning signs is an important key to effective intervention. Some common warning signs include: a preoccupation with death, making final arrangements, giving away possessions, acute personality changes, withdrawal from social activities, and an acute loss of interest or joy in their daily lives (DPBH).

Some people think that nothing can be done to help a truly suicidal person. This can be a particularly harmful myth because the truth is most people who are suicidal do not really want to die (AFSP). Instead, they just want to feel better or stop their pain (DPBH). Therefore, suicide is

preventable. Suicidal thinking is often a response to a short-lived crisis that can successfully be averted with some encouragement and support (Kaslow, 2014).

Finally, one of the most wide- spread and dangerous myths about suicide is that talking about suicide will actually encourage it to happen (AAS). In reality, talking about suicide counters the stigma and helps open lines of communication. Facilitating the sharing of feelings about fears and pain is possibly the most effective way to intervene and prevent suicide (DPBH). Suspecting that someone may be struggling with thoughts of suicide, but remaining silent is much more hurtful than talking about the issue.

Discussion

While Suicide is a taboo topic that remains mostly undiscussed in our culture, it is an issue of great importance. Today, suicide rates are the highest in 30 years (Tavernise, 2016). Women and girls have seen the most dramatic spike in suicide rates with an increase of 89 percent among American Indian women, 80 percent in middle- aged white women (Tavernise, 2016), and it has tripled among girls aged 10-14 (Bichell, 2016). The problem is made more profound when we consider the number of attempts. For every suicide, there are an estimated 25 attempts (AAS, 2015). This is a sobering fact considering that the number is likely a lower reflection of the true reality since many attempts go unreported due to the fear of stigma.

What has caused such a drastic upsurge in suicide? Several theories have emerged from various experts. Dr. Robert Putnam, Harvard Professor, says, “This is part of the larger emerging pattern of evidence of the links between poverty, hopelessness, and health.” Sociology Professor, Dr. Julie Phillips, of Rutgers University, cites social isolation as a possible component. She posits that a decline in marriage rates and a doubling divorce rate since the 1990s have contributed to less social activity and support. Finally, Dr. Alex Crosby, of the CDC, notes that

the current upswing in suicides is part of a recurrent pattern in response to economic unrest, and states, “Suicide is highest when the economy is weak” (Tavernise, 2016). Obviously, any or all of these factors including poverty, social isolation, and economic instability can be sources of great stress, which in-turn may contribute to depression and possible suicidal ideation.

However, focus is perhaps better spent of prevention and intervention rather than causes. Stress is a natural part of life and experiencing varying degrees of stress and trauma throughout life is a part of living. Interacting factors such as gender, race, age, sexuality, mental illness, and current societal trends can also impact a person’s overall risk. Therefore, the most important question is not why are people committing suicide, but rather why not. Future research is needed to explore how the factors of gender, age, and sexuality impact suicidal ideation. Understanding how these factors uniquely impact individuals and heighten their risk of suicide would allow for better intervention and prevention programs targeting these most at risk populations. Ultimately, the focus should be on what are the the most protective factors one can develop to combat stress, depression, and ultimately suicide?

Several positive measures have been recognized to successfully reduce suicide risk. In general, the most chronic risk factor of suicide among all groups is the presence of a mental illness such as depression or mood disorder (AFSP). Therefore, easy access to effective clinical care for mental disorders is imperative (CDC). Treatment for physical disease, disability, and substance abuse problems can also insulate sufferers from their negative affects and decreased suicide risk. Additionally, one of the most important protective measures against suicide is connectedness (Suicide Prevention Resource Center, 2018). Having the support of family and friends provides an avenue to open communication that can help people through times of crisis. Research of those who survive suicide attempts relieves that dying is not the primary goal of

suicide, but rather ending their emotional pain (Serani, 2013). Providing opportunities for people to seek help without fear of shame or rejection is the most important protective measure. Better intervention and prevention in the future is the best way to lower the suicide rate,

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