Suicide among african americans today

Suicide Among African Americans Today I ask myself, “ What is something that has an effect on African Americans today? ” After days of much thought and coming up with nothing I said, “ Well, I’m an African American… What’s something that has been effecting my life? ” SUICIDE… Whether it be committed or attempted, suicide is something that I see to be a growing issue among the African American culture.

I believe this to be brought on by either 1. Depression 2. Fear or 3. Mental Illness Suicide a hidden crisis that is taking the lives of more African Americans today than ever.

Nearly a million people worldwide commit suicide each year, with anywhere from 10 to 20 million suicide attempts annually. About 30, 000 people reportedly kill themselves each year in the united States. Suicide is the eighth leading cause of death in males and the 6th leading cause of death in females. It is the third leading cause of death for people 10 to 24 years of age. Suicide is a taboo subject among many cultures, but the denial of mental health disorders runs rampant among African Americans. Between 1980 and 1995, the suicide rate of black males doubled to about eight deaths per 100, 000 people.

The authors of a new book are uncovering an unspoken crisis in the African American community. Amy Alexander, author of Lay My Burden Down” was just a teenager when her brother Carl took his own life. Still reeling from the tragedy, Amy teamed up with renowned Harvard psychiatrist Alvin Poussaint to dispel the myths of suicide among the black community. “ It is very much a misperception that black people don’t commit suicide and that comes in

part from a need the very real and legitimate need for black people for many years to be very strong," says Alexander. They see mental disorder and depression as a sign of personal weakness or moral failure," says psychiatrist Alvin Poussaint, M.

D. of the Harvard Medical School. The suicide rate among black men has doubled since 1980 making suicide the third leading cause of death for black men between the ages 15 and 24. Poussaint calls his own brother's death from heroin abuse a slow form of suicide. " Psychologists and psychiatrists have to pay attention to those types of behaviors and look at them in a context in the same way they would look at someone who, in fact, was depressed or maybe suicidal," says Poussaint. Like others, African Americans may display depression through physical symptoms like headaches and stomachaches and may complain of an aching misery.

" There must be an increased awareness about the unique aspects of mental health in black Americans. " Doctor Poussaint says one reason African-Americans may not seek out professional help is because only about 2. 3% of all psychiatrists in the United States are African American. Amy feels it's important that culturally sensitive training become a part of the standard mental healthcare education process. She emphasizes mental health problems are often physically related and can be treated through talk therapy or through medication. Between 1980 and 1995, the suicide rate among black men doubled to nearly 8 deaths per 100, 000 people.

Suicide is now the third leading cause of death among black men between the ages of 15 and 24. Despite this increase in numbers, the topic of suicide

is still considered “ taboo”. While this is true nationwide among all groups, Alvin Poussaint, M. D. , a Harvard psychiatrist, says the stigma is even stronger in the black community. One problem, he says, is the stigma associated with depression itself.

More than 60 percent of black individuals don’t see depression as a mental illness, which makes it unlikely they will seek help for it. Dr. Poussaint says it goes back to the days when blues music was invented as a way to sing about pain and distress. He says blacks just consider it part of life. He also says blacks pride themselves on being strong after surviving 250 years of slavery and years of segregation and discrimination. Depression, then, is seen as a sign of weakness.

Dr. Poussaint says the first step to help is public awareness. He says, “ You can’t prevent illness or suicide if you don’t talk about it and gain some knowledge about it. ” Along with this, he says education about the warning signs of suicide is needed. These signs include: irritability, changes in appetite, changes in sleep habits, headaches, stomach aches, pain all over, sadness that continues for up to a month, spontaneous crying, social withdrawal , a loss of interest in activities and things once considered enjoyable. Dr.

Poussaint also talks about what he calls “ slow suicide. This is other self-destructive behavior that can accompany depression. This includes drug addiction, alcohol addiction, gang involvement, and other high-risk behaviors. The effects of suicidal behavior or completed suicide on friends and family members are often devastating. Individuals who lose a loved one

from suicide are more at risk for becoming preoccupied with the reason for the suicide while wanting to deny or hide the cause of death, wondering if they could have prevented it, feeling blamed for the problems that preceded the suicide, feeling rejected by their loved one, and stigmatized by others.

Survivors may experience a great range of conflicting emotions about the deceased, feeling everything from intense sadness about the loss, helpless to prevent it, longing for the person they lost, anger at the deceased for taking their own life if the suicide took place after years of physical or mental illness in their loved one. This is quite understandable given that the person they are grieving is at the same time the victim and the perpetrator of the fatal act. The effects of suicidal behavior or completed suicide on friends and family members are often devastating. Individuals who lose a loved one from suicide (suicide survivors) are more at risk for becoming preoccupied with the reason for the suicide while wanting to deny or hide the cause of death, wondering if they could have prevented it, feeling blamed for the problems that preceded the suicide, feeling rejected by their loved one, and stigmatized by others. Survivors may experience a great range of conflicting emotions about the deceased, feeling everything from intense sadness about the loss, helpless to prevent it, longing for the person they lost, anger at the deceased for taking their own life to relief if the suicide took place after years of physical or mental illness in their loved one. This is quite understandable given that the person they are grieving is at the same time the victim and the perpetrator of the fatal act.

Individuals left behind by the suicide of a loved one tend to experience complicated grief in reaction to that loss. Symptoms of grief that may be

experienced by suicide survivors include intense emotion and longings for the deceased, severely intrusive thoughts about the lost loved one, extreme feelings of isolation and emptiness, avoiding doing things that bring back memories of the departed, new or worsened sleeping problems, and having no interest in activities that the sufferer used to enjoy. Life circumstances that may immediately precede someone committing suicide include the time period of at least a week after discharge from a psychiatric hospital or a sudden change in how the person appears to feel (for example, much worse or much better). An example of a possible trigger (precipitant) for suicide is a real or imagined loss, like the breakup of a romantic relationship, moving, loss (especially if by suicide) of a friend, loss of freedom, or loss of other privileges.

Firearms are by far the most common means by which people take their life, accounting for nearly 60% of suicide deaths per year. Older people are more likely to kill themselves using a firearm compared to younger people. Some individuals commit suicide by threatening police officers, sometimes even with an unloaded gun or a fake weapon. That is commonly referred to as “ suicide by cop.

” Although firearms are the most common way people complete suicide, trying to overdose on medication is the most common way people attempt to kill themselves. What are the risk factors and protective factors for suicide? Ethnically, the highest suicide rates in the United States occur in non-Hispanic whites and in Native Americans. The lowest rates are in non-Hispanic blacks, Asians, Pacific Islanders, and Hispanics. Former Eastern bloc countries currently have the highest suicide rates worldwide, while South

America has the lowest. Geographical patterns of suicides are such that individuals who live in a rural area versus urban area and the western United States versus the eastern United States are at higher risk for killing themselves.

The majority of suicide completions take place during the spring. In most countries, women continue to attempt suicide more often, but men tend to complete suicide more often. Although the frequency of suicides for young adults has been increasing in recent years, elderly Caucasian males continue to have the highest suicide rate. Other risk factors for taking one's life include single marital status, unemployment, low income, mental illness, a history of being physically or sexually abused, a personal history of suicidal thoughts, threats or behaviors, or a family history of attempting suicide. Data regarding mental illnesses as risk factors indicate that depression, manic depression, schizophrenia, substance abuse, eating disorders, and severe anxiety increase the probability of suicide attempts and completions. Nine out of 10 people who commit suicide have a diagnosable mental illness and up to three out of four individuals who take their own life had a physical illness when they committed suicide.

Behaviors that tend to be linked with suicide attempts and completions include violence against others and self-mutilation, like slitting one's wrists or other body parts, or burning oneself. Generally, the absence of mental illness, including substance abuse, as well as the presence of a strong social support system, decrease the likelihood that a person will kill him- or herself. Having children who are younger than 18 years of age also tends to be a protective factor against mothers committing suicide. Warning signs that an

individual is imminently planning to kill themselves may include the person making a will, getting his or her affairs in order, suddenly visiting friends or family members (one last time), buying instruments of suicide like a gun, hose, rope or medications, a sudden and significant decline or improvement in mood, or writing a suicide note. Contrary to popular belief, many people who complete suicide do not tell any mental-health professional they plan to kill themselves in the months before they do so. If they communicate their plan to anyone, it is more likely to be someone with whom they are personally close, like a friend or family member.

Individuals who take their lives tend to suffer from severe anxiety, symptoms of which may include moderate alcohol abuse, insomnia, severe agitation, loss of interest in activities they used to enjoy (anhedonia), hopelessness, and persistent thoughts about the possibility of something bad happening. Since suicidal behaviors are often quite impulsive, removing firearms, medications, knives, and other instruments people often use to kill themselves can allow the individual time to think more clearly and perhaps choose a more rational way of coping with their pain. The assessment for suicidal thoughts and behaviors performed by mental-health professionals often involves an evaluation of the presence, severity, and duration of suicidal thoughts in the individuals they treat as part of a comprehensive evaluation of the person’s mental health. Therefore, in addition to asking questions about family mental-health history and about the symptoms of a variety of emotional problems (for example, anxiety, depression, mood swings, bizarre thoughts, substance abuse, eating disorders, and any history of being traumatized), practitioners frequently ask the people they evaluate

about any past or present suicidal thoughts, intent, and plans. If the individual has ever attempted suicide, the circumstances surrounding the attempt, as well as the level of dangerousness of the method and the outcome of the attempt, may be explored. Any other history of violent behavior might be evaluated.

The person’s current circumstances, like recent stressors (for example, end of a relationship, family problems), sources of support, and accessibility of weapons are often probed. What treatment the person may be receiving and how he or she has responded to treatment recently and in the past, are other issues mental-health professionals tend to explore during an evaluation. Sometimes professionals assess suicide risk by using an assessment scale. One such scale is called the SAD PERSONS Scale, which identifies risk factors for suicide as follows: Sex (male)Age younger than 19 or older than 45 years of age Depression (severe enough to be considered clinically significant) Previous suicide attempt or received mental-health services of any kind Excessive alcohol or drug use Rational thinking lost Separated, divorced, or widowed (or other ending of significant relationship) Organized suicide plan or serious attempt No or little social support Sickness or chronic medical illness Those who treat people who attempt suicide tend to adapt immediate treatment to the person’s individual needs. Those who have a responsive and intact family, good friendships, generally good social supports, and who are hopeful and have a desire to resolve conflicts may need only a brief crisis-oriented intervention.

However, those who have made previous attempts, have shown a high degree of intent to kill themselves, seem to be suffering from either severe

depression or other mental illness, are abusing alcohol or other drugs, have trouble controlling their impulses, or have families who are unwilling to commit to counseling are at higher risk and may need psychiatric hospitalization and long-term mental-health services. Suicide prevention measures that are put in place following a psychiatric hospitalization usually involve mental-health professionals trying to implement a comprehensive outpatient treatment plan prior to the individual being discharged. This is all the more important since many people fail to comply with outpatient therapy after leaving the hospital. It is often recommended that all firearms be removed from the home, because the individual may still find access to guns stored in their home, even if locked.

It is further often recommended that potentially lethal medication be locked up as a result of the attempt. Vigorous treatment of the underlying psychiatric disorder is important in decreasing short-term and long-term risk. Contracting with the person against suicide has not been shown to be especially effective in preventing suicidal behavior, but the technique may still be helpful in assessing risk since refusal to agree to refrain from harming oneself or to fail to agree to tell a specified person may indicate an intent to harm oneself. Talk therapy that focuses on helping the person understand how their thoughts and behaviors affect each other (cognitive behavioral therapy) has been found to be an effective treatment for many people who struggle with thoughts of harming themselves. School intervention programs in which teens are given support and educated about the risk factors, symptoms, and ways to manage suicidal thoughts in themselves and how to

engage adults when they or a peer expresses suicidal thinking have been found to decrease the number of times teens report attempting suicide.

Although concerns have been raised about the possibility that antidepressant medications increase the frequency of suicide attempts, mental-health professionals try to put those concerns in the context of the need to treat the severe emotional problems that are usually associated with attempting suicide and the fact that the number of suicides that are completed by mentally ill individuals seems to decrease with treatment. The effectiveness of medication treatment for depression in teens is supported by the research, particularly when medication is combined with psychotherapy. In fact, concern has been expressed that the reduction of antidepressant prescribing since the Food and Drug Administration required warning labels be placed on these medications may be related to the 18. 2% increase in U. S. youth suicides from 2003 to 2004 after a decade of steady decrease.

Mood-stabilizing medications like lithium (Lithobid), as well as medications that address bizarre thinking and/or severe anxiety, like clozapine (Clozaril), have also been found to decrease the likelihood of individuals killing themselves. Suggestions for helping people survive suicidal thinking include engaging the help of a doctor or other health professional, a spiritual advisor, or by immediately going to the closest emergency room or mental-health crisis center. In order to prevent acting on thoughts of self-harm, it is often suggested that individuals who have experienced suicidal thinking keep a written or mental list of people to call in the event that suicidal thoughts come back. Other strategies include having someone hold all medications to

prevent overdose, removing knives, guns and other weapons from the home, scheduling stress-relieving activities every day, getting together with others to prevent isolation, writing down feelings, including positive ones, and avoiding the use of alcohol or other drugs.

Grief that is associated with the suicide of a loved one presents intense and unique challenges. In addition to the already significant pain endured by anyone that loses a loved one, suicide survivors may feel guilty about having not been able to prevent their loved one from killing themselves and the myriad of conflicting emotions already discussed. Friends and family may be more likely to experience regret about whatever conflicts or other problems they had in their relationship with the deceased, and they may even feel guilty about living while their loved one is not. Therefore, individuals who lose a loved one from suicide are more at risk for becoming preoccupied with the reason for the suicide while wanting to deny or hide the cause of death, wondering if they could have prevented it, feeling blamed for the problems that preceded the suicide, feeling rejected by their loved one and stigmatized by others.

Some self-help techniques for coping with the suicide of a loved one include avoiding isolation by staying involved with others, sharing the experience by joining a support group or keeping a journal, thinking of ways to handle it when other life experiences trigger painful memories about the loss, understanding that getting better involves feeling better some days and worse on other days, resisting pressure to get over the loss, and the suicide survivor’s doing what is right for them in their efforts to recover. Generally, coping tips for grieving a death through suicide are nearly as different and

numerous as there are bereaved individuals. The bereaved individual's caring for him- or herself through continuing nutritious and regular eating habits and getting extra rest can help strengthen their ability to endure this very difficult event. Quite valuable tips for journaling as an effective way of managing bereavement rather than just stirring up painful feelings are provided by the Center for Journal Therapy.

While encouraging those who choose to write a journal to apply no strict rules to the process, some of the ideas encouraged include limiting the time journaling to 15 minutes per day or less to decrease the likelihood of worsening grief, writing how one imagines his or her life will be a year from the date of the suicide, and clearly identifying feelings to allow for easier tracking of the individual's grief process. To help children and adolescents cope emotionally with the suicide of a friend or family member, it is important to ensure they receive consistent caretaking and frequent interaction with supportive adults. All children and teens can benefit from being reassured they did not cause their loved one to kill themselves, going a long way toward lessening the developmentally appropriate tendency children and adolescents have for blaming themselves and any angry feelings they may have harbored against their lost loved one for the suicide. For school-aged and older children, appropriate participation in school, social, and extracurricular activities is necessary to a successful resolution of grief.

For adolescents, maintaining positive relationships with peers becomes important in helping teens figure out how to deal with a loved one's taking their own life. Depending on the adolescent, they even may find interactions

with peers and family more helpful than formal sources of support like their school counselor. How to best assess the risk of someone committing suicide continues to be an elusive challenge for health professionals, so it’s an appropriate goal for future research. The best way to achieve the balance between using psychiatric medication to treat any underlying conditions that may result in suicidal thoughts and the potential side effects of those medications is an ongoing issue in suicide prevention. Techniques for coping with the suicide of a loved one include nutritious eating, getting extra rest, talking to others about the experience, thinking of ways to handle painful memories, understanding their state of mind will vary, resisting pressure to grieve by any one else’s time table, and survivors doing what is right for them.

To help children and adolescents cope with the suicide of a loved one it is important to ensure they receive consistent caretaking, frequent interaction with supportive adults, and understanding of their feelings as they relate to their age.