



International Academy of Suicide Research

# IASR Newsletter

Autumn, 2017

## Welcome from the President

This year has been an exciting one for the IASR. The board is busily preparing for the Biannual IASR/AFSP Scientific Summit. The Scientific Committee, ably chaired by Drs. Yeates Conwell and Gil Zalsman, is putting together a terrific program. We have been gratified to see a very high level of participation with submissions for both oral presentations and posters from all around the world. It should be another high energy and informative meeting! Together with our outstanding partners from the American Foundation for Suicide Prevention, we look forward to seeing you in Nevada in November.

It will not surprise you to hear that the IASR Board is already thinking ahead to 2019. That is why you have received an e-mail asking your preferences in terms of location, time of year, and other factors that might influence your excitement about attending this excellent summit. If you have not yet responded, please do so as soon as you can. Naturally, we aim to find a time and place that our members prefer.

Equally important, our journal, the Archives for Suicide Research (ASR) continues to do very well under the dedicated editorship of Dr. Barbara Stanley. ASR attracts the

scientific work of top investigators and is actively seeking high quality literature reviews. You may have noticed that ASR has continued to strengthen its impact factor. To continue this important work, it is essential to be able to count on the expertise of our members who constitute a scientific community of the highest caliber. So please, when you receive that e-mail requesting that you review an article, say YES!

Finally, the IASR board would like to see an increase in the IASR membership. Please think of those colleagues who you think would be good additions. As you know, there are member categories for students and trainees (junior member), young and mid-level investigators (regular member), and senior investigators (fellow). You likely know people who would be great members. Encourage them to apply. For a list of criteria for the membership, please visit our website at <https://suicide-research.org/> Help us grow!!

See you in Las Vegas!  
Maria A. Oquendo MD, PhD  
IASR President

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# Morselli Award winners

## Victoria Arango PhD

Victoria Arango was born in Colombia and received her PhD in Neuroscience from the State University of New York, Downstate Medical Center in Brooklyn, NYC. In 1985, while at Cornell University Medical College, she pioneered anatomical studies in the brain of suicides, which she continued at the University of Pittsburgh and then in the Department of Psychiatry and the NYS Psychiatric Institute at Columbia University. She holds the rank of Professor and is the co-director of the Division of Molecular Imaging and Neuropathology. Dr. Arango's research examines brain neurotransmitter alterations in individuals who died by suicide and the effect of alcohol dependence and mood disorders on those systems. Her biochemical studies are complemented by molecular biology and neuroanatomical morphometric studies. Dr. Arango has published extensively on the neurobiology of suicide and has been continuously funded by the NIH and other Foundations for the last 30 years. She received the American Foundation for Suicide Prevention Research Award in 2010.

Dr. Arango is a Fellow of the International Academy of Suicide Research. She has played leadership roles in other prominent scientific organizations such as the American Foundation for Suicide Prevention, the American College of Neuropsychopharmacology, and the Society of Biological Psychiatry.



## Diego De Leo MD PhD

Emeritus Professor Diego De Leo was the Director of the Australian Institute for Suicide Research and Prevention (AISRAP) from 1997-2015. Professor De Leo is Past President of the International Association for Suicide Prevention and Past President of the International Academy for Suicide Research, and past and current chair of number of different committees. He has been the world leading researcher in suicide research and prevention over several decades; he has designed and advised suicide prevention activities, projects and programs around the world, including his contribution to the World Health Organization. He was in the network of consultants for the revision of ICD-10 (ICD-11) and DSM-V (Non-Suicidal Self-Injury). His work has been acknowledged with a number of different awards. In 2013, he was appointed as an Officer in the General Division of the Order of Australia, awarded for "distinguished service to medicine in the field of psychiatry as a researcher and through the creation of national and international strategies for suicide prevention".

Outputs of Prof De Leo's research activities have been presented in over 700 publications, including over 350 peer-reviewed articles, 170 book chapters and 40 volumes. His Scopus Hindex is currently 44. Prof De Leo is currently the Editor in Chief of the Crisis - The Journal of Crisis Intervention and Suicide Prevention, and an editorial board member of journals Suicide & Life Threatening Behavior, Archives of Suicide Research, Suicidology Online and Advancing Suicide Prevention. He is also Associate Editor of BMC Public Health, and Regional Editor of Behavioral Medicine and a member of the editorial boards of several other journals.





## Join us at the IASR/AFSP Suicide Summit in Henderson, NV

The International Academy of Suicide Research (IASR) and the American Foundation for Suicide Prevention (AFSP) will be hosting the 2017 International Summit on Suicide Research from November 5-8, 2017 at the Green Valley Ranch Resort in Henderson, Nevada. The IASR/AFSP Biennial Summit is a venue for participants from around the world who are invested in the study of suicide and its prevention to come together to present and discuss their latest findings. The conference provides an environment that encourages interaction and critique from other attendees through both formal and informal dialogue. It also provides leading scientists in the field, as well as early career investigators, clinicians and policy makers, with an opportunity to network and brainstorm about new research initiatives and prevention priorities. Content ranges from epidemiological through translational neuroscience to interventions, outcomes, and services research.

The program will consist of symposia, oral and poster presentations, plenary lectures and a range of other engaging approaches to sharing of the latest evidence and perspectives on suicide and its prevention. We are particularly excited about our keynote talks, which include

presentations on the refugee crisis and suicide in underserved populations; Joshua Gordon, MD, PhD, newly appointed Director of NIMH; and Maria Oquendo, MD, PhD, President of the American Psychiatric Association. As well there will be a Lived Experience Living Room Discussion and a debate on high-risk vs. population approaches to saving lives. A sampling of topics around which symposia have been organized includes military and veteran suicide; impact of suicide clusters; community based suicide prevention; neurobiology of suicide (imaging and genetics); media, social media, and suicide; psychosocial interventions; using large data in suicide research; and novel approaches to understanding and preventing suicide. Many other symposium proposals are currently under review as well.

Henderson, NV is a short shuttle ride to the Las Vegas strip and a first class resort in its own right. Please consider joining us there for the worlds premier meeting on suicide prevention research this November.

Yeates Conwell MD and Gil Zalsman MD  
Conference Co-Chairs



We look forward to seeing you in Nevada!

# Perspectives

## The Future of Suicide Research and Prevention

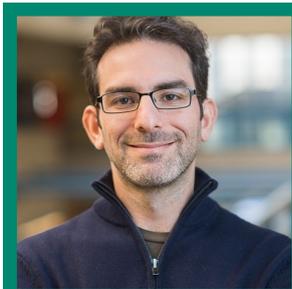
*Edited by E. David Klonsky, PhD*

It is my pleasure to serve as Guest Editor for this edition of the IASR newsletter.

It is, in my view, a unique time in the field. On the one hand, we are learning that efforts over the past 50+ years to better predict and prevent suicide have yielded limited progress [1,2]. On the other hand, recent theoretical, empirical, and methodological advances suggest the field may be poised for significant advancement [3-5].

I have therefore invited several researchers to share their perspective on a key topic: "The Future of Suicide Research and Prevention." Contributors include both established scientists and new investigators, and hail from countries around the world. You can read their perspectives on the following pages. To whet your appetite I summarize them below.

Michael Anestis PhD (University of Southern Mississippi) advocates for a public health approach to suicide prevention rather than methods focused on individual prediction. In particular, he suggests that means safety is the most potent option currently available to reduce suicide on a large scale.



**Dr. David Klonsky, University of British Columbia**

Joseph Franklin PhD (Florida State University) argues that the field of suicidology is in a "pre-paradigmatic phase," and must learn to transform beliefs (theories) into knowledge (the identification of highly necessary yet modifiable causes of suicide identified through high-quality research designs). He describes how emerging technologies such as virtual reality can help achieve this aim.

Jo Robinson PhD and Rikki Battersby BA (Orygen, The National Centre of Excellence in Youth Mental Health) focus on the youth perspective. They summarize findings from a large scale report suggesting that youth feel suicide should be discussed more openly and that technology and new media can aid with youth suicide prevention.

Gil Zalsman MD (Tel Aviv University, Columbia University) describes suicide prevention strategies from two perspectives: a recent systematic review of existing strategies, and recently established consensus principles for national suicide prevention.

Finally, Drs. Thomas Insel (Mindstrong Health, former director of NIMH) and Honor Hsin (Verily) emphasize the promise of technology. They suggest that technologies such as smart phones and mobile apps can "build care around the person" and assist with risk identification, care continuity, building support networks, and crisis intervention.

I hope you will find these perspectives as fascinating, exciting, and thought-provoking as I have.

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# Perspectives

## A public health approach is pivotal to our quest to lower the suicide rate

By: Michael Anestis PhD

Suicidology is in many ways experiencing a promising and successful series of years. The past decade has given rise to influential theories such as the Interpersonal Theory of Suicide (ITS; Joiner, 2005), the Integrated Motivational-Volitional Model (IMV; O'Connor, 2011), and the Three Step Theory of Suicide (3ST; Klonsky & May, 2014). We have also seen the validation and dissemination of evidence-based treatments specific to suicide risk and a drastic increase in the quantity of research focused on understanding and preventing suicide. Nonetheless, this same time period has been marked by more than a decade of continuous increases in the American suicide rate along with the publication of Franklin and colleagues' (2017) startling meta-analysis indicating that we have not improved our ability to prospectively predict suicide since the 1950s. The evidence that impressive work is being done is clear, but it is equally clear that our typical approach to suicide prevention is insufficient.

No panacea likely exists for this situation, but I believe that a shift in focus to a public health approach would be a pivotal step in lowering the suicide rate. Public health approaches seek to lower risk at the population level rather than aiming to diminish risk among specific individuals already identified as being in need of help. From the perspective of the Franklin et al paper, if we are no better than chance at predicting death by suicide, our prevention efforts need to be built in such a manner that we do not rely upon prediction of death. From the perspective of leading theories like the ITS, the IMV, and the 3ST, I believe there is a clear path towards doing just that. Each of these



**Dr. Michael Anestis, Univ Of Southern Mississippi**

theories emphasizes that individuals must have the desire for suicide as well as the capability to transition from ideation to action. In considering our current suicide prevention approaches, nearly all of our work focuses on preventing or mitigating suicidal desire among specific high risk individuals, with little to no attention on decreasing the capability for suicide. Such approaches require that suicidal individuals seek help, be accurately assessed for risk, and be referred to properly administered evidence-based treatments. Many hurdles exist along that path. If we were to revise our approach, however, by working to systematically decrease the capability for suicide at a population level, we would render suicidal desire less powerful by causing many suicidal individuals to be unable to act upon their thoughts of suicide. We would thus create an opportunity to lower risk universally rather than only attempting to do so downstream among individuals we believe to be at imminent risk.

As of now, the most potent intervention we have that fits this model is means safety – efforts that render specific methods for suicide either less potent or more difficult to access in a suicide. Means safety does not address suicidal thoughts, but can be implemented in a manner that reduces risk universally by encouraging safe behavior among all individuals with access to specific means. Within the US, means safety efforts focused specifically on firearms are particularly promising, whether this means legislative approaches or broad campaigns to encourage safe storage. In my opinion, the greatest challenge of the coming decade will be for researchers to develop other interventions capable of diminishing the capability for suicide at a population level and to then collaborate across professions to enable broad dissemination and implementation of those interventions. Such work may involve leveraging smart phones, machine learning, and other technology and undoubtedly will require public and private partnerships capable of optimizing reach.

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# Perspectives

## Moving from Beliefs to Knowledge: The Future of Suicide Research

By: Joseph Franklin PhD

What causes suicidal thoughts and behaviors (STBs)? I don't know and, in my opinion, no one else does either. Most of us have beliefs about these causes, but the problem with beliefs is that they don't have to reflect reality. Two people can reasonably believe in two opposing things. Such disagreements can be resolved by testing these beliefs against reality. Beliefs that repeatedly survive stringent tests against reality can be tentatively categorized as knowledge. In my view, we have little actual knowledge about suicide causes because we have not stringently tested our beliefs against reality.

Our theories are primarily beliefs about the factors and processes that cause STBs, and only experimental designs can eliminate enough alternative explanations for an association with STBs (e.g., concomitants, third variables, directionality) to permit even the weakest of causal inferences. The more alternative explanations a test can eliminate, the more stringent the test is. Correlational and longitudinal designs have low levels of stringency and cannot provide any support for causal inferences because (a) they leave open too many non-causal alternative explanations and (b) something can be a cause without being a correlate or predictor, and something can be a correlate or predictor without being a cause. As there are few experimental investigations of STB causes, there is little-to-no direct evidence to support or refute any existing theory. In such situations (i.e., what Thomas Kuhn called a pre-paradigmatic phase of a scientific field), a large number of theories co-exist until there is sufficient evidence to convince most of the field to

adopt a particular theory. The suicide field has been in this pre-paradigmatic phase for over 100 years. It is time for our field to make progress by prioritizing high quality experimental tests of our theories.

But at least two issues complicate these tests. First, obvious ethical issues preclude any direct experimental tests involving actual suicidal behaviors. Recent advances in virtual reality (VR) technology provide an opportunity to overcome this long-standing impediment. These new VR systems are relatively inexpensive and easy-to-use, and it is possible to program a wide range of suicide-relevant scenarios. Although virtual suicidal behaviors are certainly not isomorphic with suicidal behaviors, they are realistic enough to permit the first cogent laboratory tests of potential causes of suicidal behaviors.

Second, recent meta-analytic and machine learning evidence converges on the idea that STB causes are highly complex, requiring complicated combinations of hundreds of biopsychosocial factors. Given this complexity and the fact that most experiments can only test one or two factors at a time, how can experiments provide meaningful information? The answer is that not all causes are equal; suicide research should prioritize the identification of causes that are (a) highly necessary for a subset of STBs to occur and (b) viable intervention targets. Such causes may be poor correlates and predictors of STBs (because such factors are far from sufficient causes), but may nevertheless be essential for a subset of STBs to occur. Means restriction and safety programs, which are the best-supported type of suicide intervention, directly target these kinds of factors. Guns and other potentially lethal means are not sufficient for suicide to occur but they are, by definition, necessary. Future research should employ experiments to identify other types of factors that are causal, highly necessary, and viable.

Many fields of inquiry can afford the luxury of beliefs, but the suicide research field is not one of them. To prevent the needless deaths of hundreds of thousands of people each year, we must begin the hard work of transforming our beliefs into knowledge.



**Dr. Joseph Franklin, Florida State University**

# Perspectives

## Future directions in youth suicide prevention: the role of technology and youth participation

By: Jo Robinson PhD and Rikki Battersby BA

Suicide rates in young people are increasing around the western world. Many countries have national suicide prevention strategies in place, which frequently identify young people as a group at particularly high risk. However the increases in the number of young people taking their own lives suggests that we need to think differently, and it stands to reason that young people themselves need to be part of that thinking process.

Orygen recently developed a large-scale report, *Raising the Bar for Youth Suicide Prevention*<sup>1</sup> and in doing so we conducted an extensive consultation with young people. The views that came back were that not only did young people want to be part of a solution but that they believed we need to talk more openly about suicide, and that technology and new media need to be part of the fix.

Whilst clinicians and researchers are experts-by-training, young people add value as experts-by-experience; an area of expertise that otherwise might be missed. With technology developing at a rapid rate, the world that young people live in today is very different than the world current researchers and clinicians would have lived in as young people. Young people contribute by sharing their lived experience around what it means to be a young person in 2017 and with regard to how technology impacts their everyday life – for better and for worse.

Indeed the advent of social media has presented a series of both challenges and opportunities for suicide prevention. It promotes connectedness among young people but it has also never been easier to share potentially harmful or distressing content.

Traditionally, media-based suicide prevention approaches have focused on safe reporting of suicide in more static forms of media but with young people as the creators of their own content a different approach is required. Additionally, given its increasing popularity we also need to consider how, as a sector, we can capitalise on the opportunities that newer forms of media provide in terms of preventative efforts.

A recent study did apply a different approach. In the *Bayside Safe Conversations* study<sup>2</sup> we worked with four groups of young people providing education about how to communicate safely about suicide online and worked them to create their own suicide prevention messaging that could be delivered to other young people via social media.

Young people found participation beneficial and it has led to a national project that is currently being developed in Australia in which young people will co-design their own suicide prevention social media campaign. They will also develop a suite of educational resources designed to help (continued next page)



Dr. Jo Robinson and Ms. Rikki Battersby, Orygen, The National Centre of Excellence in Youth Mental Health

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other young people communicate safely online about this sensitive issue. This project provides an opportunity for us to partner with young people to develop safe suicide prevention messaging and resources that actually resonate with young people.

The most effective way to ensure that future suicide prevention efforts which seek to help young people *actually*

do help young people is to truly co-design and co-develop them *with* young people. Young people want to be part of the solution, they want open conversations about suicide and they see technology as an integral part of that solution. Thus we if are to reverse the rising trend in youth suicide rates we need to listen to these views and develop approaches that address the needs of young people in this digital world in which we now live.

1. Beach video - depicted a young man standing on the beach alone, with the words "feeling crap?" written in the sand. Another man then approaches him and they walk off arm-in-arm together; a wave then washes away the first message and leaves behind the words "people are there for you".

Duration: 0.55; author/s: three males aged 18-19.



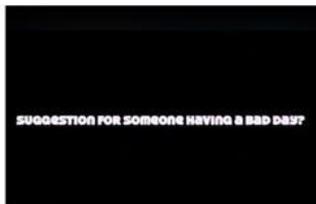
7. Letter video - featured a young man writing a letter to his friend who had died by suicide, in which he discusses his regret about not checking in with his friend sooner. The video was accompanied by sad piano music and the overall mood was more melancholy than the other videos.

Duration: 2.44; author/s: male aged 16.



2. Vox pop - featured short clips of interviews with young people answering the following questions: "What makes you happy?", "What makes you sad?", "Suggestions for someone having a bad day?", and "Do you think it's easy for people to talk about their feelings?".

Duration: 3.16; author/s: female aged 19.



6. Suicide can't be reverse - featured reversed footage of items breaking or spilling, with the final message that "suicide can't be reverse".

Duration: 1.07; author/s: two males aged 16.



3. Signs video - featured imagery of road signs, with the overarching message that "suicide is not the answer" and that there are places you can go to seek help.

Duration: 0.31; author/s: male aged 20.



7. Mask video - more comedic, and showed two friends having a very robotic conversation about their perfect lives whilst smiling maniacally. The video ended with the message "you don't have to keep your mask on - if you feel like you always have to hide your feelings then you should seek help".

Duration: 0.56; author/s: two males aged 16 & 17.



4. Post-it-note video - depicted scenes of people writing messages to their friends on post-it notes, with the overall message encouraging viewers to ask their friends if they are ok.

Duration: 1.10; author/s: four males aged 15.



8. Series of four images - each image contained a positive or motivating message, for example, "when it rains look for a rainbow, when it's dark look for stars".

Duration: N/A; author/s: female aged 17.



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# Perspectives

## Suicide Prevention Strategies Revisited

By: Gil Salzman MD

National prevention programs have been proven to lower number of suicides and rise service use. The first major review of the effectiveness of approaches to suicide prevention by Mann and colleagues was published in 2005 [1]. We recently conducted a systematic review using similar methodology to assess progress in suicide prevention research since that influential publication [2].

By searching PUBMED and the Cochrane library for all relevant English language publications over the last decade. Suicide prevention experts from 13 European countries reviewed 1700 articles and rated the strength of evidence using the Oxford criteria [3]. Papers that had enough evidence included systematic reviews and meta-analyses (n=35), randomized controlled (RCT) (n=40), cohorts (n=67) and ecological or population-based (n=22). We found that restricting access to lethal means clearly prevents suicide. School-based awareness programs reveal significant results in RCTs in reducing suicide attempts and ideation. The anti-suicide effect of Clozapine and Lithium was confirmed but may be less specific than previously thought before. Effective treatment of depression, pharmacological as well as psychological, remains an important suicide and self-harm prevention strategy. As to the education of physicians, a direct association with decreased suicide rates is difficult to establish. Evidence remains insufficient regarding the benefits of screening in the primary-care population, and in, public and media education in reducing suicide.



Dr. Gil Zalsman, Tel Aviv University and Columbia University

In another recent publication [4] we tried to have a consensus on the principles of national suicide prevention. The following principles were agreed upon: 1. Every European country should conceptualize a suicide prevention program. 2. A suicide prevention taskforce should be established in each country to implement the program. 3. The suicide prevention strategy should be separate from the general mental health strategy and have independent funding, yet be coordinated with it. 4. A scientific evaluation program should accompany every national program. 5. Each country should monitor standardized validated data on annual rates of attempted and completed suicides. 6. Data regarding the amount of financial support of each national suicide prevention taskforce should be recorded as well as what percentage of the GDP and of the total national budget for prevention represents. And finally 7. The suicide prevention program, the taskforce and the evaluation of the program should be funded by the respective governments.

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# Perspectives

## Bending the Curve with Technology

By: Thomas R. Insel MD and Honor Hsin MD PhD

Looking at the persistently high rates of suicide over the past two decades, there can be little doubt that we need to do better. In spite of widespread public awareness campaigns, a broad range of research on risk, and several government task force reports, the inconvenient truth is that more people are dying from suicide today than at the turn of the century.

Why have we failed to bend the curve? The usual answer from suicide researchers is that we don't know enough: more research on prediction and prevention will reveal solutions that can bend the curve. The answer from public health officials is that we don't do enough: we have failed to implement solutions that we already know about. It is probably a safe bet to argue that we need both to know more and to do more, but the urgent question is how to implement the current knowledge so that we can start to save lives now and not in a decade.

A recent Australian report reviewed the available scientific literature on strategies that could reduce suicide to predict population preventable fractions for each strategy.<sup>(1)</sup> While data were lacking on some approaches, of seven strategies (reducing access to suicide means, media guidelines, public health campaigns, gatekeeper programs, school programs, general practitioner training, psychotherapy and coordinated/assertive aftercare), the top ranked for reducing suicide deaths were general practitioner training and psychotherapy. The Research Task

Force report of the Action Alliance for Suicide Prevention also stressed the role of better treatment and aftercare (although also stressing the role of reducing access to means).<sup>(2)</sup>

What are the impediments to providing proper treatment? There are at least three areas where we can immediately improve our treatment efforts. First, until recently, suicidality has not been a target for treatment. With the emergence of medications and psychosocial treatments for suicidality, we now have an opportunity to improve our interventions specifically to reduce mortality from suicide.<sup>(3)</sup> Second, we know that making a suicide attempt is a major risk factor for ultimately dying from suicide. One in five suicide deaths has been seen in an emergency room for an attempt in the year prior to death.<sup>(4)</sup> The data on follow up after emergency room visits suggests that up to 70% of people who have attempted suicide do not follow up with a first outpatient visit and nationally only 33% of patients are seen in the first week following discharge from psychiatric hospitalization. <sup>(5, 6)</sup>

But perhaps the most difficult challenge is that many people who die from suicide have not been in treatment. One recent study estimates that 60% of fatalities are from a first attempt (or at least the first attempt that receives medical attention).<sup>(7)</sup> That is where the third opportunity arises. While not everyone is in treatment nearly everyone interacts with a smartphone (continued next page)



Dr. Thomas Insel, Mindstrong Health



Dr. Honor Hsin, Verily

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or social media, giving us for the first time a ubiquitous platform for both risk detection and intervention. Twitter and Facebook posts as well as online search patterns have been used to identify individuals at risk for suicide within the population.<sup>(8)</sup> Importantly, this approach can potentially identify proximal risk factors in contrast to our field's tradition of looking at factors that are months or years away from an attempt. Online interventions from peer support to text-based crisis intervention can now provide "just in time", on demand prevention at scale. Rather than relying on traditional paths of screening, these technologies offer the potential of an entirely new ecosystem of virtual gatekeepers and crisis responders. We do not yet know if these population-based approaches will reduce suicide and there remain challenging issues of trust and privacy, but the advent of this new approach promises unprecedented access to the large percentage of people who are not yet patients.

Perhaps most importantly, we need to remember that treatment saves lives. Smartphones and mobile apps also offer the opportunity to access psychosocial intervention modules or coaching resources that could enhance traditional treatment, or provide support where clinicians are not readily available. Yes, we can use biomarkers for detecting risk and we will do better with rapid treatments that reduce suicidality, but we can "do more" with treatments we have today simply by focusing on those at high risk because they have made an attempt, they have been recently discharged from inpatient care, or they have confessed to suicidal intent online. Technology offers us a potential new platform for identifying risk, ensuring continuity of care, building support networks, and "just in time" interventions. As technology builds care around the person, it may offer our best hope for bending the curve.

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# Research Update

## Effectiveness of treatments for people who self-harm: a review of current evidence

By Keith Hawton MD

'Self-harm' refers to intentional self-poisoning or self-injury irrespective of suicidal or other motivations. Thus it includes both attempted suicide and non-suicidal acts of self-poisoning and self-injury. Self-harm is often repeated and is strongly associated with an increased risk of suicide. It is a major problem in many countries, reflects high levels of distress and has significant impacts on family and friends. Self-harm also places large demands on health care services worldwide. It is unsurprising therefore that improved treatment for people who self-harm is a key element in national suicide prevention strategies.

In a recent review of randomized controlled trials, published in and the Cochrane Database of Systematic Reviews and The Lancet Psychiatry, with the collaboration of an international group of authors, we have investigated the effectiveness of different forms of psychosocial therapies for adults who self-harm. The main finding was that by the end of follow up people who had received CBT-based psychological therapy were less likely to self-harm than those who received usual care. While the effect was relatively modest, following CBT 6% fewer people self-harmed when compared with those who did not get CBT, significant benefits of the treatment were also found for depressed mood, hopelessness and suicidal thoughts. While most of the studies were small, and also acknowledging that short-term CBT-based psychological therapy will not be suitable for all patients who self-harm, we believe that taken together the evidence provides grounds for recommending that access to this type of treatment should be available through self-harm services.

The review also showed that dialectical behavioural therapy can help reduce the frequency of repetition of self-harm in people with a history of multiple episodes. Evidence for the effects of other therapeutic approaches are less clear because they have mostly been evaluated in small single trials.

In a further review, also published in the Cochrane Database of Systematic Reviews, we investigated the effectiveness of pharmacological (drug) treatments

for adults. Only a small number of eligible trials were found and with little current evidence for benefits of pharmacological treatments in this population.

In a third Cochrane review of treatments for children and adolescents who self-harm there was some evidence of benefit in single trials of dialectical behavioural therapy and mentalization therapy in terms of reduced frequency of self-harm, and also that a special therapeutic assessment increased attendance at therapy sessions.

The results of these reviews provide some guidance for clinicians and patients. However, there is clearly a need for further investigations of potentially effective treatments, especially for the large numbers of children and adolescents who self-harm.

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Professor Keith Hawton, Oxford University

# New members

## Bridget Matarazzo PsyD

Dr. Bridget Matarazzo completed her Pre-Doctoral Internship at the Denver VA Medical Center and obtained her PsyD in Clinical Psychology from the University of Denver in 2010. She is a licensed Psychologist in the state of Colorado and has been working in the VA's Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) for Suicide Prevention since 2010, where she is currently the Director of Clinical Services. She is also

an Assistant Professor in the Department of Psychiatry at the University of Colorado, School of Medicine. She Co-Directs the VA's National Suicide Risk Management Consultation Program, is the National Clinical Lead for the VA's innovative REACH VET program and is the developer of the Home-Based Mental Health Evaluation (HOME) Program. Her primary research interests are related to engaging Veterans at high risk for suicide in care.



Golan Shahar, Ph.D., serves as Professor of Clinical-Health psychology at Ben-Gurion University of the Negev, Israel, where he directs the Stress, Self, and Health Lab. He also serves as Adjunct Professor at the Yale Child Study Center of Yale University School of Medicine. Shahar has received his academic degrees at Ben-Gurion University of the Negev in Israel (1990-1999), has taught at Bar-Ilan University (also in Israel, 1999-2000), and has obtained post-doctoral training in clinical and developmental psychology at Yale University (2000-2002). He then joined the Department of Psychiatry at Yale University School of Medicine and served there in the rank of Assistant Professor for two years (2002-

2004). At the end of 2004, Shahar came back to his Alma Mater, Ben-Gurion University of the Negev. His research focuses on the interplay between stress and the self-concept in psychopathology, particularly depression and suicidality, and in adolescent and young adult development. In his theoretical-clinical work, Shahar develops a comprehensive perspective on the integration of psycho-therapeutic interventions. Shahar is the author of over 150 publications and an authored book titled *Erosion: The Psychopathology of Self-Criticism* (<https://global.oup.com/academic/product/erosion-9780199929368?cc=il&lang=en&#>). He is the outgoing Chief Editor of *Journal of Psychotherapy Integration*.

## Golan Shahar PhD

If you have not yet paid your 2015 membership fees, you can do so online. IASR is reliant on your fees:

[www.suicide-research.org/membership](http://www.suicide-research.org/membership)



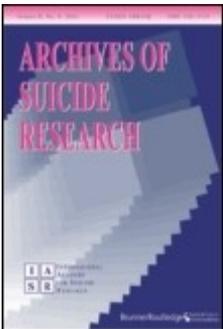
## Kairi Kõlves PhD

Dr Kairi Kõlves is a Principal Research Fellow and Course Convener at the Australian Institute for Suicide Research and Prevention (AISRAP), Griffith University. She has been working in suicide research and prevention since 1998. Between 1999 and 2008, she worked at the Estonian-Swedish Mental Health and Suicidology Institute and joined AISRAP in 2008. Dr Kõlves has been involved in several Australian, Estonian and international-projects and has been an adviser to the World Health Organization. She is

a member of a number of advisory committees including the Commonwealth Department of Health's Expert Panel on Suicide Prevention, the Queensland Advisory Group on Suicide, and the Advisory Board of 'Lifeline Research Foundation'. Her work has been published in over 80 peer-reviewed papers, a number of book chapters and numerous reports.

## Archives of Suicide Research

*EDITOR-IN-CHIEF: Barbara Stanley*



Archives of Suicide Research, the official journal of the International Academy of Suicide Research (IASR), is an international journal in the field of suicidology. The journal features original, refereed contributions on the study of suicide, suicidal behavior, its causes and effects, its prevention and intervention. The journal publishes articles investigating the biological, pharmacological, genetic, psychological, epidemiological and sociological aspects of suicide. In addition to original research articles, the journal publishes high quality literature reviews relevant to suicidal behavior.

The editors of ASR are mindful of the di-

chotomy between general (quantitative/nomothetic) methods of research and practice and approaches that utilize specific case studies (qualitative/idiographic). While eagerly accepting work from suicidologists situated on both sides of this division, the editors ultimately wish to cultivate a forum that attempts to reconcile and merge these oppositional modes. It is their belief that, by amalgamating the general and the specific, the field of suicidology will become a more scientific discipline - a discipline that encourages the open exchange of knowledge and techniques. And it is the mission of ASR to be the primary conduit through which the results of such exchanges will be enthusiastically disseminated.

**Please consider submitting your research to ASR**

## Impressum

The Newsletter of the International Academy of Suicide Research was prepared by your contributions.

Responsible for the text:

E. David Klonsky  
Annette Erlangsen  
Rory O'Connor

**Commit to the  
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