• Immediate Help. Are you having thoughts of suicide right now?  
• Please follow this link: Suicide: Get Help Now or CALL US at 707-826-3236. We are here for you 24/7.  
• You can text this crisis text line:  
• You can also CALL National Crisis Hotlines at 1-800-273-TALK (1-800-273-8255) or 1-800-SUICIDE (1-800-784-2433).  
• Helpful Handouts  
• PDF with local and national Suicide Prevention Resources from Humboldt County Dept. of Health & Human Services.  
• PDF for those who are concerned about someone else's possible suicide risk: Suicide Warning Signs and Clues & How to Help  
• Information and Advice: The Issue is Suicide  
• The Issue is Suicide: Myths and Facts  
• Check out the CAPS Pinterest Board on Depression and Suicide Prevention  
  
The below materials were taken from THE ISSUE IS SUICIDE by Ralph L. Rickgarn of the University of Minnesota.  
  
Suicide is not a neutral word. Suicide is not a neutral behavior. As a word, it evokes powerful emotional reactions regardless of the outcome. Fear, anxiety, disbelief and anger are but a few of the emotions that create an atmosphere which impedes involvement in the issues of suicide. As a consequence, attitudes and actions of avoidance and indifference occur. However, with adequate information and the creation of realistic expectations, this avoidance and indifference may be alleviated and replaced with positive actions and reactions.  
  
Suicide is a traumatic event for the individual and for all of those people who have some connection with that person.  
  
Suicide is a highly individualized behavior in reaction to multiple life stressors and interactions that have produced negative or perceived negative outcome.  
  
The following is written to provide a framework of information and some methods of intervention. It is written in the hope that all members of the university will engage in the creation of a caring and confrontative community with some alternatives.  
  
The question for an individual who becomes aware that another person is possibly contemplating suicide is, "Is this person here with me right now wanting to commit suicide and what can I do about it?"  
  
An encounter with a suicidal person is always a deeply emotional experience. There is a fear of not knowing what to do, or doing the wrong thing. But the basic empathic, "I care about you", indicates that there is hope and help, two key ingredients in the intervention process. Misinformation often prevents individuals from becoming involved for fear of making a situation worse. There are many myths about suicide which deter individuals from becoming involved. What are the myths and what are the facts?  
  
MYTH: People who talk about suicide rarely attempt or complete suicide. FACT: Approximately 70-75% of the people who attempt or complete suicide have given some verbal or non-verbal clue to their intentions. MYTH: Asking, "Are you thinking about committing suicide?" will lead the person to a suicide attempt. FACT: Asking direct, caring questions will often minimize the anxiety and act as a deterrent to suicidal behavior. MYTH: The tendency toward suicide is inherited. FACT: Suicide has no characteristic genetic quality. Suicidal patterns in a family are the result of other factors and may result from a belief in the myth which facilitates suicidal actions. MYTH: The suicidal person wants to die. FACT: Suicidal persons often reveal considerable ambivalence about living vs. dying and frequently call for help before and after a suicide attempt. FACT: Depression is often associated with suicidal feelings but not all persons who attempt or commit suicide are depressed. A number of other emotional factors may be involved. FACT: Many persons who have attempted or committed suicide would not have been diagnosed as mentally ill. MYTH: Once an attempt has been made, the suicidal person will always be suicidal. FACT: After a suicide attempt, a person may be able to "manage" and engage in no further suicidal action. MYTH: Suicide is more common in lower socio-economic groups. FACT: Studies of persons who have completed suicide indicate that 50% have sought medical help within six months of their action. FACT: Persons who have attempted or completed suicide usually give some indication of their intended behavior. MYTH: Motives or causes of suicide are readily established. FACT: Suicide is usually a lengthy and complex pattern of behavior where precise motives are difficult to ascertain. FACT: From studies it appears that neither suicide or attempted suicide is significantly related to weather phenomenon. MYTH: Improvement in a suicidal person means the danger is over. FACT: There is a significant danger within the first 90 days after a suicidal person is released from hospitalization. FACT: Suicide prevention by lay persons and centers has been an important, significant part of suicide prevention activities.  
  
These myths and facts were synthesized from works by Blimling and Miltenberger (1981), Resnik (1968), Resnik and Hawthorne (1973) and Schneidman and Farberow (1961).  
  
Approximately 70-75% of the individuals who attempt or commit suicide DO GIVE some indication of their impending action. Gollman (1971) lists some indicators of susceptibility toward self-destruction.  
• Chronic Use of Other Chemicals  
  
There is no single pattern or causative factor in suicide. However, most often there is an indication of hopelessness,a great deal of personal pain, and a belief that things are "out of control". These two feelings in particular are strong indicators of potential suicide. All indicators must be taken seriously.  
  
How to respond or begin!  
• The best intervention is to ask directly and caringly:  
  
 ARE YOU THINKING ABOUT SUICIDE? Questions like, "You're not thinking of suicide are you?" indicate that the answer you want to hear is, "No, I'm not", and do nothing to facilitate a resolution of the individual's suicidal crisis.  
  
REMEMBER: Asking will not put the idea into the person's head. Relief is often apparent when someone cares and is willing to talk. This can lead to an exploration of alternatives and a release of pent-up feelings.  
• Some assessment of the circumstances needs to be made. How lethal is the proposed method of suicide? What are the person's exact intentions? Is there a specific plan? The lethality of the plan can range from a well thought out action involving a very lethal method (hanging, shooting, poisoning, or jumping) to a very low level of lethality (a nebulous idea with little feasibility of succeeding). THE MORE SPECIFIC THE PLAN, THE HIGHER THE RISK. Determining the method available is important. Any pills, guns, knives, should be removed for safekeeping.  
• Never promise total confidentiality. Explain that you may need to discuss the situation with another individual in order to provide the best possible service.  
• Verbally and non-verbally indicate your genuine concern. Be willing to discuss the suicidal thoughts and feelings of the individual.  
• If possible, involve the person in a SUICIDE CONTRACT (this can be done verbally or in writing). Contracts can serve as a block to behavior. Sounds strange, but it works.  
• Refer the individual to an appropriate agency for assistance. Be willing to accompany the person to the initial contact session or intake. Support is very important.  
  
An attempted or completed suicide is always a traumatic experience in any setting. The survivors have to deal with the initial shock element and the aftermath of the trauma. Different reactions are experienced by peers, colleagues, staff, friends, faculty, parents , and significant others. Particularly in a residence hall, staff need to be aware of these reactions in order to respond appropriately.  
  
Any or all of the following may be present:  
• Anger - Both at the person and at self.  
• Blame - "I should have been able to..."  
• Guilt - "It's my fault for not ...."  
  
These are some of the most common reactions. Grief is a common reaction in survivors. Individuals may experience periods of denial, rage, anger, bargaining, depression and acceptance. Grief is not measured only in fears and withdrawal, but equally in life, continuing to survive, grow and reach out to others.  
  
"The person who commits suicide puts his psychological skeleton in the survivor's closet." (Schneidman, 1969, p.22)  
  
Where there is a completed suicide or an attempt, Schneidman's statement rather succinctly defines what happens. Individuals do not want to be placed in the position of having to cope with someone's "psychological skeleton" Consequently, the tendency to avoid or to appear indifferent toward suicide occurs. Hopefully, with information and the development of a caring, responding attitude, the University community can respond to individuals who are suicidal in a positive and confrontative manner. And this same caring can also be shown to the survivors.  
• ASK & Prevent Suicide: includes warning signs associated with suicidal behavior, what to do, access to crisis lines. Free. Versions for iOS and Android.  
• Jason Foundation A Friend Asks: how to help a friend who might be thinking of suicide. Provides warning signs, do's and don'ts, and the National Suicide Prevention Lifeline, etc. Free. Versions for iOS and Android..  
• ReliefLink: this innovative suicide prevention/mental health app won a $50,000 prize at a White House conference! It includes mood and behavior monitoring and tracking, safety planning, medications and appointment reminders, a help center map locator, built-in coping tools, & an emergency button. Free. For iOS.