

Suicide Among Women: A Critical Review

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Suicidology has progressed during the past 2 decades, with the development of psychological autopsies, large national databases, and a national imperative to understand and prevent suicide. Despite its growth, current research contributes little to a comprehensive understanding of the factors that influence suicidal behaviors in women. Before considering the complexities of suicide among women, we must establish *why* it is imperative that researchers, public health advocates, policy makers, and clinicians address this critical issue at both population and individual levels.

Why Study Suicide in Women?

Mortality is measured as the “worst” outcome of disease. Hence, medical research often aims at identifying and combating risk factors for fatal outcomes. Studies that exclude associated morbidity fail to capture important sources of disease burden. For example, suicide is the greatest cause of death among psychiatric patients, but it is only the “tip of the iceberg.” At its base lies an array of psychiatric and social pathologies that contribute to a range of suicidal behaviors and outcomes.

As the urgency to combat suicide and its antecedent conditions has grown, the preponderance of attention has been given to suicide among men, with relative silence about its impact on women. Suicides among men in the United States outnumber those among women fourfold. When morbidity and mortality are considered together, however, the weight of disease burden shifts heavily toward women. At a minimum, suicide attempts occur 10 times as often as suicide,¹ and women account for the majority of reported attempts.² Depression, which is highly prevalent among men and women who

Despite increasing attention to suicide as a preventable outcome associated with mood disorders, little attention has been given to the risk factors for suicide among women. In this paper, we: 1) review the current literature regarding risk factors for suicide among women; 2) address the theories regarding risk and protective factors for women; 3) integrate the findings into a practical assessment of women's risk of suicide in clinical settings; and 4) consider avenues for future research. (*JAMWA*. 2004;59:125-134)

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Table 1. International Suicide Rates per 100 000 Among Men and Women, 2002*

Country	Year	Men	Women	M/F Ratio
Australia	1999	21.2	5.1	4.0:1.0
Austria	2000	29.3	10.4	3.0:1.0
Belarus	1999	61.1	10.0	6.0:1.0
Bulgaria	1999	24.1	8.1	3.0:1.0
China (selected areas)	1998	13.4	14.8	0.9:1.0
China (Hong Kong SAR)	1999	16.7	9.8	1.7:1.0
Denmark	1998	20.9	8.1	2.5:1.0
Hungary	2000	51.5	15.4	3.3:1.0
Japan	1999	36.5	14.1	2.5:1.0
Netherlands	1999	13.0	6.3	2.0:1.0
Russian Federation	1998	62.6	11.6	5.4:1.0

*Data from World Health Organization.⁵

commit suicide, disproportionately affects women. It is with this broader perspective that the need to critically study suicide among women becomes clear.

No one understands what factors put some women at greater risk of suicide. What are the similarities or differences between women who kill themselves and those who attempt suicide but do not die? How do these relate to an even broader group who engage in self-injurious behaviors? This paper does not answer these questions but lays the groundwork for future exploration by focusing on data surrounding suicide deaths among women.

In this paper, we briefly review what is known, what is missing, and the practical aspects of assessing women in clinical settings. We focus on suicide in adult women, but draw on available literature about serious attempts. We present studies conducted primarily in the United States, but data from international samples also are considered when relevant. The objectives are to: 1) review current data on rates and risk factors for female suicides gleaned from studies that present sex-specific findings, 2) describe theories for differences between men and women with

regard to suicide, 3) discuss the implications for clinical practice, and 4) consider avenues for future research.

Methodological Limitations of Suicide Research

There are many challenges to conducting suicide research, including defining the broad range of suicidal behaviors, overcoming inconsistencies and misclassifications of death certificates and records, and addressing the lack of prospective epidemiological studies among large representative population samples in the United States. Because the rates are relatively low in women compared with men, the hurdles are even higher when conducting research to understand the risk and protective factors for suicide among women.

The inconsistent use of terminology is one problem that must be understood when interpreting the literature. Terms such as suicidal ideation, suicide attempt, and parasuicidal behavior are often misused or combined under the heading “suicidal behaviors.” To improve clarity, O’Carroll et al³ proposed the following commonly used classifications. *Suicide* is “a death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted *and* that the decedent intended to kill himself/herself.” *Suicide attempt* is “a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence (either explicit or implicit), that the individual intended at some (nonzero) level to kill himself/herself.” *Suicidal ideation* is “any self-reported thoughts of engaging in suicide-related behavior.” This paper focuses on suicide as defined above.

Epidemiology of Suicide Among Women

The demographic factors most often cited when considering suicide risk are gender, age, race, and marital status. Many clinicians are aware that the demographic factors associated with the highest rates of suicide are being male, white, elderly, and single (divorced/widowed). Although critical, this information has limited applicability to women. Who are the women who die by suicide, and how can we identify those at risk?

According to the Centers for Disease Control and Prevention, the rate of suicide among women in the United States was 4.0 per 100 000 in 2000, which meant that 5732 women died from suicide.⁴ This is one-quarter the rate among men (17.1 deaths/100 000 or 23 618 men). This 4:1 ratio has remained constant since 1989 and is consistent with international patterns, with the exception of rural China⁵ (Table 1). A multitude of factors likely contributes to the sex dif-

ferences in suicide rates. Aggregate rates tell only a part of the story and must be evaluated in more detail.

Suicide rates differ among women by age. The rate of suicide among women ages 20 to 64 declined 16% between 1980 and 1994.⁶ Despite the decline, the greatest burden for suicide deaths and the highest rates of suicide are among women between the ages of 35 and 64⁴ (Table 2). This pattern differs from that of men, among whom the greatest number of suicides occur in the early to middle adult years (25-54) and the greatest rates occur in the older adult years (>65). These distinctly different patterns among men and women may provide clues to the prevalence of modifiable risk factors for different age groups and genders.

Studies of suicide among minority women in the United States are virtually nonexistent. It is well established that suicide rates among black women in the United States (1.7/100 000) are lower than those of white women (4.4/100 000) or women of “other” races (3.0/100 000) (in 2000).⁴ The low rates among black women are thought to be related to the protective factors of extended family networks and religion, but further work is needed to fully understand this phenomenon.⁷

One demographic variable that is not often considered is geographic location. Suicide rates vary considerably by region. For example, Alaska had the highest rate of female suicides (8.2/100 000) in 2000, and the District of Columbia had the lowest (1.6/100 000).⁴ The western states also have a high rate of female suicides (ie, Nevada and New Mexico 7.0/100 000, Oregon and Utah 6.5/100 000, Wyoming and Arizona 6.1/100 000). Regional variability may reflect a variety of factors, including risks associated with the age of the population, the ethnic or racial cohorts of the region, access to and availability of mental health treatment, and access to and familiarity with firearms.

Marriage is often reported as a protection against suicide, with a particularly strong effect for men.^{8,9} The strength of marriage as a protective factor in women is less robust, but is suggested by multiple studies.¹⁰⁻¹⁴ There are many limitations in our understanding of this demographic factor. Few have delineated marital status into a continuum of categories (never married, widowed, divorced, separated, married), and even fewer have noted living arrangements or partnered (heterosexual or same sex) relationships. Marital status is often used as a proxy for social integration or relationship embeddedness. However, the quality of or satisfaction with the relationship is rarely established. For example, intimate partner violence has been associated with increased rates of suicide attempts,^{15,16} but its effect on suicide risk has not been established.

Table 2. Suicide Rates Among US Women, 2000*

Age Group	Number of Deaths	Crude Death Rate per 100 000
5-9	1	0.0
10-14	62	0.6
15-19	270	2.7
20-24	300	3.2
25-34	854	4.3
35-44	1448	6.4
45-54	1288	6.7
55-64	680	5.4
65-74	404	4.0
75-84	297	4.0
85 and over	128	4.2

*Includes ICD 10 Codes X60-X84 intentional self-harm and Y87-Y87.0 sequelae from intentional self-harm. Data from Centers for Disease Control.⁴

Because most suicide studies have not asked specifically about partnered relationships, data on suicide risk in lesbian and bisexual women are lacking. Research is limited primarily to the study of suicide attempts among adolescents. These data suggest an increased risk of suicide attempts among lesbian, gay, and bisexual adolescents compared with heterosexual adolescents but provide no information about the risk of suicide.¹⁷

How Are Women Different?

Current data provide some insight into areas for investigation and highlight similarities and differences in men and women that may allow for the development of sex- or age-specific prevention initiatives.

Psychopathology

There are 3 primary approaches to studying psychiatric illness and suicide: 1) psychological autopsies compare the psychological profiles, including psychiatric diagnoses, of those who die by suicide with those of living controls; 2) studies of psychiatric patient populations compare patients who do and do not kill themselves; and 3) studies of medical records link birth, death, and psychiatric hospitalization databases. National linked databases are not readily available

Table 3. Prevalence of Affective Disorders and Substance Abuse Among Female Suicides in International Studies

Study	Country	Year	Women, No.	Affective Disorders, %	Substance Use, %
Barraclough, et al ¹⁰	England	1967-1969	47	Depression, 72	Alcoholism, 6
Rihmer, et al ⁵⁵	Hungary	1985	97	Major depression, 46	...
Asgard ⁵⁶	Sweden	1982	104	Depressive disorder, 59 Adjustment disorder, 14	Alcohol abuse, past month, 7 Narcotic abuse, past month, 5
Cheng ⁵⁷	East Taiwan	1989-1990	45	Major depression, 91 Dysthymia, 33	Alcohol abuse, 24
Heila, et al ⁵⁸	Finland	1987-1988	24 (with schizophrenia)	Depression, overall, 59 ages 33-44, 88 ages 16-32, 67 ages 45-79, 25	Alcohol, overall, 13 ages 33-44, 25 ages 16-32, 17

in the United States. The closest such database is the 1993 National Mortality Followback Survey, which includes deaths from all causes from 49 states and has been used to compare those who died of suicide with those who died of other causes.¹⁸

The most robust and compelling finding for men and women who commit suicide is the high prevalence of psychiatric illness.^{12,19} All major affective, psychotic, anxiety, and substance abuse disorders have been shown to increase the risk of suicide.²⁰ One obvious paradox exists, however. Major depression, which has repeatedly been found to be a significant risk factor for suicide,^{20,21} affects women in the early and middle years of life at twice the rate of men, yet women die by suicide at one-quarter the rate of men. In later life, the rates of depression may be roughly equal, but the suicide rate in men skyrockets while the rate in women drops. These data argue that major depression alone is insufficient to account for suicide and does not explain sex differences in suicide rates.

Depression is highly prevalent among women who die by suicide. The prevalence of depressive disorders in selected studies from European and Asian countries is between 59% and 91%, with similarly high rates in the United States (Tables 3 and 4). One investigative team concluded that the prevalence of depression was greater among women who committed suicide than in the general population.²²

The lifetime suicide mortality for patients with major affective disorder is generally believed to be 15%,²¹ but ranges from 5% to 26% depending on the study population.²³ Beyond the existence of depression, the chronicity and severity of the disorder may also affect risk. A study of patient subpopulations found the lifetime risk of suicide to be 8.6% among formerly hospitalized patients following suicidal behavior, 4.0% among formerly hospitalized patients with affective disorders, and 2.2% among outpatients with primarily affective disorders.²⁴ Sex differences were not noted in these studies. One review article did estimate the risk of suicide separately for men (7%) and women (1%) with major depression.²⁵

Among women who die by suicide, alcohol abuse is also highly prevalent. In the 5 studies that reported alcohol or other substance abuse, between 5% and 17% of women met study criteria (Tables 3 and 4). One limitation in interpreting these data is that studies used different criteria. Some studies described substance abuse histories, and others defined current substance abuse. At least 2 studies suggested an increased risk of suicide among women with alcohol or substance abuse.^{20,22} Two studies described similar rates of alcohol use at the time of death among men and women (25%-30%)^{26,27} (Table 4). The use of alcohol at the time of suicide may reflect a substance use disorder, the need to be intoxicated to follow through, or the impulsivity associated with intoxication. Regardless, further research is needed to

Table 4. Prevalence of Affective Disorders and Substance Use Among Female Suicides, United States

Study	Location	Year	Women, No.	Affective Disorders, %	Substance Abuse, %
Rich ²²	San Diego County, California	11/1981 - 6/1983	61	Depression, >50	Substance use, 17
Garlow ²⁶	Georgia	1994-1998	68	...	Alcohol detected at the autopsy, 30
Runyan, et al ²⁷	North Carolina	1989 - 1993	177	Depression history, 62	Alcohol detected at the autopsy, 25 Alcoholism history, 10

understand the role of alcohol or other substances in women's suicide.

Additional Clinical Indicators

A prospective longitudinal study of depressed patients that did not report sex-specific findings found that particular depressive symptoms (hopelessness, anhedonia, insomnia, psychic anxiety),^{28,29} panic attacks,²⁸ persistent affective morbidity,³⁰ delusions,³⁰ and comorbid alcohol abuse³¹ were associated with an increased risk of suicide. A history of serious suicide attempts³⁰ and suicidal ideation³¹ were also associated with greater suicide risk. Investigators evaluated short- (within 1 year of the index depression) and long-term risk (1 year or more after the index episode) of suicide and found that personality characteristics, specifically impulsivity and assertiveness, were associated with long-term but not short-term risk.³¹ Finally, violent behavior and aggression have been shown to be significant predictors of suicide, especially among women.³² Although violence itself is not a psychiatric disorder, it may be a marker for affective, substance use, psychotic, or personality disorders.

Pregnancy and Parenthood

Being pregnant^{33,34} and having young children in the home^{12,13,29,35,36} have each been found to have a protective effect against maternal suicide. The duration of the protective effect of parenthood is unknown and is not absolute. For example, investigators found an increased risk among parents who experienced the death of a child or whose child had a psychiatric illness.^{12, 13} Another exception is in the case of postpartum psychiatric illness, which is associated with an increased suicide risk³⁷ (Table 5). Some studies also suggest a higher rate of suicide among women who have undergone induced abortions.³⁸

Education and Employment

Whether the risk of suicide is affected by economic status is an area of extensive exploration. As women have become more formally involved in the work force, it is even more important to understand this relationship. Overall female suicide rates appear to be unaffected by unemployment.^{13,39,40} Despite a rise in unemployment among women in the United States between 1972 and 1986, there was a decrease in the female suicide rate.³⁹

Specific types of employment may confer greater suicide risk. Data from death certificates of adult female suicides between 1975 and 1979 from 4 states revealed that suicide rates were greatest among the "moderately traditional" job holders, followed by "nontraditional" jobs, and finally those in "highly traditional" jobs.⁴¹ Although the findings are interesting, they are difficult to interpret, as the author neither defined the types of employment in each category nor provided the final sample size for the analysis.

Using the National Mortality Followback Survey, researchers found that women who died by suicide were more likely to have higher levels of education than women who died from natural causes.¹⁸ This finding is consistent with studies in which higher rates of suicide among women physicians were found when compared with women in the general population or women working in other professions.^{42,43} Women physicians in Finland had a standardized mortality ratio of 2.4 and 3.7 between 1986 and 1993 when compared with women in the general population and women professionals respectively.⁴³ Similarly, increased rates of suicide have been found among US women physicians.^{44,45} In contrast, American women physicians had a lower than expected prevalence of suicide attempts (1.5%).⁴⁶ The study's authors commented that the lower attempt rate may reflect higher completion rates among women physicians than women in the general population.

Table 5. Studies of Pregnancy, Parenthood, and Suicide

Study	Location	Design	Women, No.	Findings
Qin & Mortensen ¹³	Denmark	Nested case-control; longitudinal register databases; suicides 1/1981- 12/1997	Cases 6500 Controls 130 000	Suicides: Less likely to have children under 18 ($p < .001$); risk decreased with increasing number of children ($p < .01$). Increased risk of suicide if child with psychiatric disorder but only if the mother did not have history of psychiatric admission. More likely to have child who died, especially ages 1-6 (OR 4.7). More likely to have child who died within the previous month (OR 76.05). More likely to have child 18 or older who committed suicide (OR 3.47).
Reardon, et al ³⁸	California	Medicaid records for birth or induced abortion in 1989 linked to death certificates 1989 - 1997	173 279 53 suicides	Women who had induced abortions had significantly higher age-adjusted risk of suicide compared with women who delivered (2.54)
Appleby, et al ³⁷	Denmark	Danish psychiatric case register, medical birth register, register of causes of death 1973-1993	1567 women admitted to psychiatric hospital, 107 died. 19 died within 1 year of childbirth	52 suicides (49% of deaths, 3.3% of sample) 14 (27% of suicides, 0.9% of sample) suicides within 1 year of childbirth 17-fold increase in suicide risk long term 7-fold risk of suicide in year following childbirth
Marzuk, et al ⁵⁹	New York City	Autopsy reports female suicides, ages 10-44, 1990-1993	315 suicides: 6 pregnant (3 black, 3 white)	Observed 3.85/100 000 Expected 18.45/100 000
Gissler, et al ⁶⁰	Finland	Death certificates were linked with birth, abortion and hospital discharge registers, 1987-1994	1347 suicides: 73 suicides associated with pregnancy; 30 after birth; 29 after abortion; 14 after miscarriage	Significantly lower suicide rate than population (per 100 000) Births (5.9 vs. 11.3) OR = 0.52 Significantly higher suicide rates than population (per 100 000) Miscarriage (18.1) OR=1.61 Abortion (34.7) OR=3.08
Dannenberg ⁶¹	New York City	Medical examiner's records	115 injury-related maternal deaths; 15 suicides	13% suicides
Hoyer and Lund ⁶²	Norway	Prospective; 1970 census linked to deaths in the Central Bureau of Statistics for 11/1970-10/1985	989 949 single or married women 25 years or older: 1190 suicides over 15 years	Lower risk for parous married (RR 0.8)
Appleby ⁶³	England and Wales	Death certificates of women age 15-44, 1973-1984	76 suicides in year following childbirth; 14 suicides while pregnant	Postnatal SMR=0.17 Pregnancy SMR=0.05

Others have speculated that the higher rates of suicide among male and female physicians may be because of the combination of access to lethal means and a sophisticated

understanding of anatomy and physiology. Other professions that have elevated rates of female suicide include police officers (4 times the general population rate)⁴⁷ and Navy

Table 6. Risk Factors of Suicide in Women

Increased Suicide Risk	Decreased Suicide Risk
Psychiatric Illness Depression Anhedonia* Hopelessness* Insomnia* Anxiety* Persistent symptoms* Psychotic symptoms (delusions)* Substance Use or Abuse	Young children (under 18 years old) in the home
Personality Characteristics* Impulsive* Aggressive History of violence	Pregnancy
Psychiatric History Psychiatric hospitalization Postpartum psychiatric hospitalization History of suicide attempts	
Family History Suicide* Child has died Child has psychiatric illness	
Demographic Characteristics Single or unmarried Higher levels of education Middle-aged	
Firearm Access	

* Risk factors identified in mixed gender groups, not specific to women

personnel (1.3 times the civilian rate).⁴⁸ All of these may be considered “nontraditional” professions for women, and all have potentially contributing factors, such as access to and familiarity with lethal means. Further studies are required to understand the individual characteristics of women involved in these professions as well as the social and cultural stressors associated with performing these jobs.

Means of Suicide

It is often noted that women choose “less lethal means” (eg, overdose, wrist cutting) than men do. Many consider the choice of means to be responsible, in part, for the distribution of female and male suicides and suicide attempts. With this in mind, it often surprises clinicians that, for more than a decade, firearms have been the most

common method of suicide among women. In 2000, firearms accounted for 37% (n=2132) of female suicides, followed by overdose (31%, n=1752), hanging (17%, n=955), and all other forms (15%, n=893).⁴ The use of firearms is not limited to young women; there was a 46% increase in the use of firearms (24% to 35%) among older women who died by suicide between 1980 and 1992.⁴⁹ Increasing familiarity with and access to firearms are the hypothesized causes of the increase. Access to firearms increases the odds of suicide for both sexes.¹⁸

Comparing Male and Female Suicides

A substantial body of literature exists about factors that may protect women against suicide. Interpretation of these factors derives primarily from considering why men die of suicide more often than women do. One explanation is that women use less lethal means than men do. A study comparing 61 female suicides with 143 male suicides found that 43% of the women used “more immediately fatal means” (defined as firearms, hanging, jumping) compared with 75% of men.²² It is well-established that women attempt suicide with nonlethal means more often than men do, however, it is also true that when suicide attempts are defined as serious (ie, requiring medical attention), the incidence among men and women is equal.⁵⁰ Because of the sex distribution of suicide attempts and deaths, the literature is heavily skewed toward risk factors for suicide attempts among women and, conversely, risk factors for suicide deaths among men. From the current literature we cannot know whether suicide attempters are inherently different from completers or not. However, these 2 groups overlap with regard to common psychiatric disorders.⁵¹

A second prominent theory is that women’s “social embeddedness” is protective. Parenthood can be protective,¹³ although its protective value is not absolute and must be considered in the context of other factors. It has also been hypothesized that women are at greater risk of suicide when they deviate from traditional roles. Declining rates of suicide among women as they increasingly enter traditional male professions fail to support this notion, but it is true that there is a higher rate of suicide among certain, nontraditional professions.

Finally, because women use mental health services more than men do, it would follow that women are more likely to be treated for depression or other contributing psychiatric illnesses and therefore would be at lower risk of suicide. This hypothesis does not explain the high rates of suicide attempts among women, however, nor can it be the only

explanation, as more than half of women with depression remain undiagnosed or un- or undertreated.^{52, 53}

Clinical Implications

How can physicians identify the woman at risk of suicide? Physicians can use the information gained at a population level to guide and enhance their assessment of an individual woman (Table 6). The available data highlight the need to ask about psychopathology, including symptoms of depression or bipolar disorder; alcohol and substance abuse; previous psychiatric history, including inpatient hospitalizations and suicide attempts, delusions, history of violence, impulsivity, or aggressive behavior. Physicians also should ask about a woman's access to and familiarity with firearms; her relationships, including marital, parental, and reproductive status; her children's health status; her family history of suicide; her level of education; her age; and her profession. No suicide scale exists to total these risk factors and decide a woman's overall risk, but inquiring systematically about these factors provides physicians an avenue to explore the woman's state of mind. At the same time, it is an opening to direct inquiry about key components of any suicide assessment.

Suicide assessment requires direct questioning of the patient about her wishes to live or die, specific thoughts about killing herself, plans to carry out an act, access to and lethality of means. The American Psychiatric Association practice guideline for the assessment of suicidal behaviors provides a comprehensive list of more than 40 questions that can help clinicians assess suicidal thoughts, plans, and behaviors.⁵⁴ Initial questions address patients' feelings about living ("Have you ever thought that life was not worth living?" "Did you ever wish you could go to sleep and just not wake up?"). These are followed by questions that address specific thoughts about death, self-harm, and suicide ("Have things ever reached the point that you've thought of harming yourself?"). If thoughts of self-harm are endorsed, physicians should evaluate the details of the thoughts, including the nature, intensity, frequency, timing, persistence, and circumstances.

Hopelessness is a particularly strong predictor of suicide, and therefore questions addressing hope must be included. For example, physicians may ask, "How does your future look to you?" "What things would lead you to feel

more (or less) hopeful about the future?"⁵⁴ Physicians must also ask whether the patient has made a specific plan. If so, what is the plan? Does the patient have access to the plan or the means? Routinely asking about pills, household poisons, firearms, or access to dangerous settings is critical. Has the patient made preparations for the plan or for after her death (eg, purchasing the means, writing a will, arranging for child care)? Answers to each of these questions will help physicians evaluate the immediate safety of the patient and consider the short- and long-term needs of the patient.

Assessment of suicidality must occur throughout the ups and downs of depression. Individuals in the midst of recovering from major depression may be *more lethal* as they are "getting better." Major depression is a syndrome that combines subjective emotional states and objective signs such as speed of movement, speech, and thought output. It may appear that someone is improved as her antidepressant

takes effect. Yet, this improvement may not immediately involve the subjective aspects of her mood disorder. (Often one hears, "you look so much better," while the patient responds, "but I don't feel *any* better." Both can be correct!) At such times, the risk of suicide may be increased. Additionally, recovery from the subjective aspects of a severe mood disorder need not be "all or nothing." She may feel "better" for a time and then be overcome with brief waves of dysphoria or distress. Such recurrences may be sufficient to bring

on a sense of failure and hopelessness, and given access to lethal means, provide the impetus for a lethal attempt.

Physicians must appraise the total picture, including ideation, implementation, diagnosis, and "demography," that is, how closely she conforms to all of the risk factors discussed. If the level of concern is so high that you feel the need for an expert assessment of her risk of self-harm or suicide, it is time to refer her for an immediate psychiatric assessment and possible hospitalization. Resources for these evaluations differ among communities. Options for further assessment may include private psychiatrists, psychiatric nurses, nurse practitioners, or social workers. Usually private providers are unable to accommodate immediate assessments but are an important resource for short- and long-term assessment, treatment, and collaboration. Some community and county mental health centers have crisis appointments for such assessments, and others may have a

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mobile crisis or outreach team. Many communities have toll-free numbers or suicide hotlines that can guide you to local resources. Emergency departments may offer psychiatric evaluations and hospitalization. If a patient is acutely suicidal, do not leave her alone. She may require transportation to the emergency room via family escort, police escort, or ambulance. Finally, several organizations maintain helpful Web sites: Suicide Prevention Resource Center (www.sprc.org), American Association of Suicidology (www.suicidology.org), and the American Foundation for Suicide Prevention (www.afsp.org).

Future Directions

Studying suicide among women in the United States will facilitate exploration of risk factors for multiple outcomes of which suicide is the most adverse. Gathering data for statistical analyses will require a cooperative, multistate initiative to provide enough cases to identify risk and protective factors at a population level. Although

comparisons between male and female suicides may be useful in establishing areas of research, they are of limited value. Questions must begin from female-centered hypotheses rather than simply applying findings from male suicides. In addition to psychiatric histories and diagnoses, studies must comprehensively explore the meanings of family (immediate and extended), relationships (same sex as well as opposite sex), work, children, reproductive status, violence, and firearm familiarity. We must develop prospective studies to explore the relationship between suicidal ideation, suicide attempts, and suicide among women. It is time to push these issues to the forefront of our public health agenda if we wish to fundamentally improve the quality – and duration – of the lives of many women who now suffer or die.

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