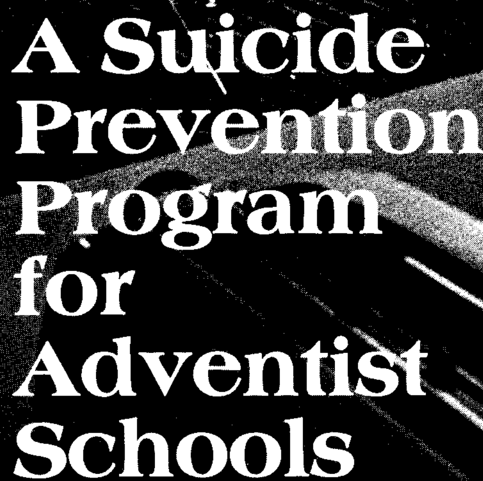

A Suicide Prevention Program for Adventist Schools

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An epidemic is sweeping the country. It is taking the lives of young people at an alarming rate. It's not tuberculosis, typhoid, or smallpox—the great scourges of the past. We can't deal with this epidemic by enacting public health laws, for it is self-inflicted. It's the epidemic of teenage suicide.

Adolescent suicide rates have more than doubled since 1960. In 1980, suicide became the second leading cause of death among 15-24 year olds.[1] Students in church schools are not immune, although teachers are not usually aware of this until one of their students takes that final step. Promoting positive attitudes and preventing self-destructive behavior must be given top priority by educators and health professionals.

To prevent teenage suicide, a comprehensive systems approach is needed, one that involves the family,

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school, and community resources.

I Wish I Were Dead

"My daughter wants to die; she's said so many times," the mother told me on the telephone, referring to Betty, her 14-year-old.

"Bring her to the office next Tuesday, and I'll make an assessment," I replied. After she hung up I thought to myself, "Black people aren't at high risk for suicide. Furthermore, if the child were serious, her mother wouldn't be talking about it that calmly."

When Betty came in with her mother, she didn't look suicidal. She was neatly dressed, well-groomed, quite personable. "No," I thought, "definitely not suicidal."

As a precautionary measure, I had asked Dr. Barker, my clinical supervisor, to sit in on the session. I asked Betty some questions about a trip she and her mother planned to take. I consciously steered away from negative topics.

Dr. Barker broke in. Looking directly at Betty, he asked, "Have you thought about killing yourself?"

"Yes," she replied.

"Have you made any attempts?" the doctor prodded. Again, the answer was Yes.

"What did you do?" he asked.

"I shot my mother's insulin twice in my leg and once in my arm."

"How much did you shoot?"

"Fifty milligrams." She knew the exact amount.

"Why did you try this?"

Betty looked at her mother, turned back, and slowly replied, "I was trying to kill myself. I tried the week before, too."

"How long have you been thinking about killing yourself?" Dr. Barker persisted.

"For about a month," she said.

"Have you told anyone?"

"Yes, my boyfriend," she replied.

"What happened that made you want to do this?"

"My mother got mad and yelled at me. I couldn't stand it, so I thought I'd get out of her way. . ." Betty ended tentatively.

Her mother and I sat there utterly baffled as we listened to Betty describe her feelings of hurt and rejection to Dr. Barker. How could we have been so blind as to miss Betty's cues? How could I, a therapist, have misdiagnosed her symptoms as a typical adolescent behavior disorder?

The answer is threefold: (1) We were unaware of the signs, symptoms, and gestures of suicidal behavior; (2) We hadn't thought of the reality of suicide as a life-and-death phenomenon; and (3) each of us—the family, school, and myself as a therapist in the Community Mental Health Agency—had neglected our responsibility to prevent adolescent suicide. By ignoring the signs we had played Russian roulette with Betty's life.

The Problem

Suicide rates for 15 to 24-year-olds rose from 5.2 to 12.3 per 100,000 between 1960 and 1980, a 237 percent increase. White males have the highest rate of this age group (70 percent); followed by white females (22 percent). Six percent are black and other males, with only two percent being black and other females. While white males succeed more often, white females are making more attempts. For every male who commits suicide, approximately three females will attempt to do so. Ninety percent of suicide attempters are female; 75 percent of actual suicides are male.

The lethality of weapons accounts for some of the differences between survivors and nonsurvivors. Use of lethal weapons increased for both males and females between 1960 and 1980. Firearms and explosives became the leading methods of suicide for both sexes.[2]

	Firearms/explosives	
	1970	1980
Males	58.4%	63.1%
Females	30.2%	38.6%

This change is significant, particularly among females, who have traditionally used less lethal methods, such as poisoning or drug overdoses. The use of

more lethal methods decreases the chance of rescue and survival.

Adolescents are most vulnerable to suicide. They are going through so many changes so quickly that they may feel they lack control over their lives. Adolescence is a time of mood swings, feelings of loneliness, anger, fear, guilt, and worthlessness as well as other negative emotions. It is also a time of firsts—new experiences, independence, accomplishments, and pleasures.

What makes a young person feel so hopeless that he or she no longer wants to live? Why is suicide on the rise? Some child specialists believe that, while adolescents have always gone through physical and emotional changes, they face additional pressures today. Although they have greater social freedom—with more choices and information—they often lack a framework for sorting out their values.

Because of the post-World War II baby boom, there are simply more people than ever before, which means more competition for grades, college, jobs, and attention. This pressure is found throughout the world. Students in many developing countries know they may have only one chance in school: if they fail, suicide seems the only alternative.

Adolescence can be a very lonely time. Every teenager feels he or she is going through these changes alone. We must help students understand that they are *not* alone.

Everyone occasionally feels insecure, frustrated, or depressed. Momentary suicidal feelings or thoughts are not uncommon among teenagers. These feelings do not make them crazy or psychotic.

During this stressful period of adolescence, many teenagers get little support from their families. An increasing number are growing up in one-parent households, or in homes with stepparents. Many young, upwardly mobile parents have little time to spend with their children.

A Suicidal Personality?

There is no such thing as a typical suicidal person. Suicide is so widely dispersed throughout the population that it affects virtually all types of people. As such, it is one of the very few things that is truly democratic!

We do know, however, that loss of a parent due to death, divorce, desertion, but especially by suicide, prior to a child's fifth birthday is a strong predisposing factor.[3] A study by the Los Angeles Suicide Prevention Center reported that of suicides in the 15 to 19-year-old group, 50 percent were "diagnosed as having learning disabilities, were victims of dyslexia, hyperactive, suffered extreme loss of self-esteem . . . a hopeless feeling they could never catch up."[4]

Suicidal teens typically view themselves as helpless, see their situations as hopeless, and have lives that are hapless. Many who seemed to have everything going for them may change suddenly when confronted with new situations in which they are not viewed as outstanding. The academy basketball team captain who has no chance to shine his first year in college; the girls' club president who finds her choice of study at a beauty school leads to a dead end; both may see suicide as a way to end their pain.

Suicide is rarely spontaneous. No one wakes up, stretches, looks out the window, and says, "What a wonderful day to kill myself." On the contrary, suicide is usually the result of a long-term, gradual wearing-away process. Although the breaking of a romance or the loss of a coveted position may be the precipitating factor, it is not the cause of the suicide.[5] The seeds of suicide are often sown in childhood.

A suicidal crisis usually concerns two people—the suicidal person and "the significant other." This may be a parent, lover, sibling, or admired teacher. Many times the crisis is precipitated by broken communications between the two. Restoring that communication is the simplest way to resolve the crisis.[6]

Warning Signs

Teenagers contemplating suicide often give clues to their intentions. Here are some warning signs to watch for:

- **Threatening to commit suicide**
- **Previous suicide attempt**
- **Personality changes (withdrawal, aggression, or moodiness)**
- **Depression (changes in appetite and sleep disturbances)**
- **Dramatic drop in school performance**
- **Themes of suicide, death, or depression in essays or artwork**
- **Loss of friends**
- **Unusual neglect of appearance**
- **Running away**
- **Verbal hints such as "I won't be a problem to you much longer," "It's no use," or "I won't see you again"**
- **Becoming suddenly cheerful after a period of depression**
- **Putting his or her affairs in order—for example, giving away prized possessions, cleaning his or her room, throwing things away, making a will.[3]**

Illogical Thinking a Sign

Suicidal adolescents do not think logically about situations that confront them. If they did, they probably wouldn't be suicidal. Because of illogical thinking, they choose a permanent solution to what is often a temporary problem. Such individuals need to be repeatedly reminded of the transitory

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or not one understands it or believes it."

The late Hilda Taba, an early researcher in social-studies thinking skills, sagaciously pointed out almost 20 years ago the links between adult development, teacher practice, and children's learning, noting that when teachers themselves operate at lower conceptual levels, children tend to adopt irrational, unproductive, and arbitrary models of thinking that depend on memory and authority rather than judgment and inference.

Given this evidence, we suggest that education reformers must give careful attention to teachers' own cognitive development as plans are made for teachers to develop more sophisticated thinking skills in their students.

There is a critical link between improving teachers' ability to instill such skills in others and teachers' own roles within the schools. Perhaps Albert Shanker had a good sense of teachers' developmental levels when he predicted that they will only eventually become supportive of professionalism, because for too long they have existed in a world of rules and regulations where someone else makes the decisions. Enhancing teachers' effectiveness in encouraging critical thinking and intelligent decisionmaking must be part of the effort to make teaching a more responsible and less passive occupation.

Teachers must be encouraged to engage in a new level of self-management and decisionmaking in their schools and classrooms. Schools must become places where creative and flexible thinking is encouraged, where teachers use processes that allow for group planning, problemsolving, and cooperative learning, and where personal growth is encouraged in a variety of ways. The principles of school-based management offer a sound model for such efforts.

Teachers must also be involved in curriculum development. Too often teachers have only been dispensers of commercial materials with hundreds of objectives to be covered. This has done much to foster the trivialization of knowledge. Teachers need instead to see the relatedness of the different elements of the curriculum and help students link learning across subjects. Before teachers can be expected to develop new interrelated curricula, however, they may need a deeper level of knowledge in and across content areas to make up for a fragmentary college education.

Moreover, if students are to cooperate in teams, learn how to learn, and learn how to think flexibly, teachers must use materials that reflect multiple viewpoints. Again, teachers who may have been schooled in only one way to view things may need to learn to appreciate varying viewpoints and become comfortable in dealing with and presenting them to students.

Much work at many levels is needed to bring about *a vision of teachers as thinkers and informed decisionmakers*. But until a school building radiates this conception of teaching, it is unlikely that trying to teach children higher-order thinking will succeed. Just as we commonly accept that parents transmit subtle and often unconscious attitudes, world views, and problem-solving approaches to their children, so teachers must become aware of the impact that their own ways of thinking have on students. This requires that teachers be willing to examine their own assumptions to clarify how they think and make decisions.

Our comments are not meant to disparage teachers. Again, the evidence shows deficiencies among college graduates in many disciplines, and there is much work to be done to modify practices in higher education. Our concern here is to point out the adult-development needs of teachers who may have been ill-served in their initial preparation. To have the teaching force make the significant mindshifts needed to support the emphasis on higher order thinking is an incredibly challenging task. Without attending to the challenge, however, there seems little long-range hope that this emphasis can succeed. □

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SUICIDE PREVENTION PROGRAM FOR ADVENTIST SCHOOLS

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nature of the crisis.

Suicidal people may also use circular logic: "I'm going to kill myself."

"Why is that?"

"Because my problems can't be solved."

"How do you know they can't be solved?"

"Are you kidding? If my problems could be solved, do you think I'd be talking about killing myself?"

Some motivations for committing suicide are wanting to escape an intolerable situation, seeking to gain attention, manipulate others, avoid punishment for a crime, punish the "significant other," or obtain revenge.

Do's and Don't's for Helping a Troubled Teen

DO trust your instincts if you suspect a teenager is suicidal.

DO communicate your concern. Listen to the young person's problems and offer support.

DO talk openly. Ask direct questions about the teenager's intention. Try to determine if he or she has a suicide plan (how, when, where). The more detailed the plan, the more serious the threat.

DO recognize your limitations. Obtain professional help from a psychologist, mental health counselor, minister, psychiatrist, or school nurse.

DO remind the young person of his or her importance in God's eyes. Speak of God's love for us regardless of the situation. The parable of the prodigal son best illustrates that love: the father didn't wait to hear apologies or rea-

Myths About Suicide

Before a teacher or staff member can deal with troubled teenagers, he or she needs to dispel common myths about suicide. The accompanying list details some of these misconceptions:

MYTH: People who talk about killing themselves rarely do so. FACT: Most people who commit suicide have given some clue or warning of their intent. Suicide threats and attempts should always be treated seriously.

MYTH: The tendency toward suicide is inherited. FACT: Although suicide does seem to run in families, it does not appear to be transmitted genetically.

MYTH: The suicidal person wants to die and feels that there is no turning back. FACT: Suicidal individuals are often ambivalent about dying and call for help immediately following a suicide attempt.

MYTH: All suicidal persons are deeply depressed. FACT: Not all people who kill themselves are obviously depressed. In fact, some appear to be happier than they've been in quite a while because they have decided to "resolve" all their problems by suicide.

MYTH: Suicidal persons are mentally ill. FACT: Although many suicidal people are depressed and distraught, few would be diagnosed as mentally ill.

MYTH: If someone attempts suicide, he or she will always thereafter entertain thoughts of suicide. FACT: Most people are suicidal for only a brief period. With proper assistance and support, they will probably never feel this way again. Only about 10 percent of suicide attempters later complete the act.

MYTH: Asking a suicidal person about his or her intentions may encourage that person to kill himself or herself. FACT: Actually, the opposite is true. Inquiring directly about suicide will often lower the anxiety level and act as a deterrent to suicidal behavior by helping the person ventilate pent-up emotions.

MYTH: When the depression lifts, there is no longer any danger of suicide. FACT: The greatest danger of suicide exists during the first three months after a person recovers from a deep depression.

MYTH: Suicide is spontaneous. FACT: Most suicidal persons plan their action in advance and give clues of their intentions.[8]

sons. His love was unconditional (Luke 15:18-29).

DON'T assume the teenager "isn't the type" to commit suicide.

DON'T leave the young person alone if you believe the risk of suicide is imminent.

DON'T act shocked at what a teenager tells you.

DON'T debate the rightness or wrongness of suicide. Moralizing may make the young person feel more guilty and intensify the depression.

What a School Can Do

The school can network with other agencies in the community. Together educators, parents, and health professionals can promote preventive interventions before adolescents self-destruct. Networking of these resource persons also provides a buffer against the projection of blame on everyone involved if a suicide does occur.

Second, conduct awareness sessions for faculty and staff. Teach the warning signals of potential suicide, the do's and don't's, of how to deal with such situations. Emphasize the importance of alerting other faculty members as well as family and mental health professionals to possible suicide attempts. Don't let a student fall through the cracks of the system.

Next, train some faculty members specifically to deal with suicide. Ideally, a school counselor, psychologist, or school nurse could fill this role. Unfortunately, not all schools have such trained professionals. Any caring person who receives proper training can be called upon in time of emergency. Persons trained in suicide prevention should not be negative, pessimistic, judgmental, authoritarian, or moralizing.

Lastly, institute an educational program for students. The topic can be discussed in a mental health unit or in Bible class. The curriculum described below will teach better ways of coping with problems, and help students to have a more understanding attitude toward others with problems.

Such a unit should include:[9]

I. Reasons for Suicide
   A. Revenge—feeling angry, spiteful, hostile
   B. Isolation—loneliness, feeling no one cares; having something to hide (incest, drug abuse, homosexual experience)
   C. Hopelessness—seeing no way out (pregnancy, child of divorce, abuse, or alcoholism), feeling out of control
   D. Failure—perception is more important than reality
   E. Loss—the most important cause of suicide (death, divorce, moving to new school, breakup of romantic relationship, victim of rape, loss of body part)

II. Warning signs and behaviors
   A. Acute suicidal behavior—frequent mention of suicide, saying good-byes, giving away prized possessions, extreme mood swings, extreme behavior changes, anorexia or bulimia, general apathy, attempted suicide
   B. Chronic suicidal behavior—substance abuse, consistent reckless driving, high-risk hobby without appropriate precautions, accident-prone tendencies

III. How can you help?
   A. Recognize warnings. Really look and listen.
   B. Don't try to handle person alone. Get help from minister, family, school staff.
   C. Talk about suicide—let person know he or she is being taken seriously.
   D. Tell person, "I care, you aren't alone."
   E. Provide alternatives.
   F. Get help, go along if necessary.
   G. Help person find one reason to live, something to look forward to.
   H. Convince person that death is final and irreversible.
   I. Do not act shocked or make judgments. Do not make person feel crazy, stupid, or guilty.
   J. Be accepting, even if you do not

approve of the person's solution to the problem.

IV. Consider Bible promises on the worth of the individual.
   A. Romans 8:16 "We are the children of God . . ."
   B. Psalm 103:13 "Like as a Father pitieth his children . . ."
   C. Proverbs 14:26 "His children shall have a place of refuge."
   D. Jeremiah 49:11 "Leave thy fatherless children, I will preserve them alive . . ."
   E. Isaiah 54:13 "Great shall be the peace of thy children."
   F. Philippians 4:13 "I can do all things through Christ . . ."
   G. Psalm 145:15, 16 "Thou givest them their meat in due season . . . and satisfiest the desire of every living thing."
   H. Hebrews 2:11 "For which cause He is not ashamed to call them brethren . . ."
   I. 1 John 3:1 "Behold, what manner of love the Father hath bestowed upon us, that we should be called the sons of God . . ."
   J. Hebrews 4:15 "We have. . .a high priest which . . . was in all points tempted like as we are . . ."
   K. Psalm 34:18 "The Lord is nigh unto them that are of a broken heart . . ."
   L. Ezekiel 18:32 "For I have no pleasure in the death of him that dieth . . . wherefore turn yourselves, and live ye . . ."
   M. Jeremiah 31:3 "Yea, I have loved thee with an everlasting love: therefore with lovingkindness have I drawn thee."
   N. Isaiah 49:15 "Can a woman forget her sucking child? . . . yea, they may forget, yet will I not forget thee."

V. Suggested activities
   A. Have students write a letter convincing someone their own age not to commit suicide.
   B. Suggest role-playing situations (a) manning a suicide hotline, (b) one friend telling another that he or she is contemplating suicide, (c) one friend questioning another about possible suicide.
   C. Use case-study approach; ask students how they would respond, what they would do.

Conclusion

Our adolescents do not have to self-destruct. Adolescence is not terminal, it is transitional. This transition can be either creative or destructive. We can prevent teen suicide by sending our students the loud, clear message, "You're not alone. We—your teachers, your family, your church—will take the adolescent journey with you. We love you and want to help." □

Suggested Resource Materials

Greg Laurie, *Teenage Suicide: The Ultimate Weapon*, Answers From the Bible. Booklet available from Harvest Ministries, 6115 Arlington Ave., Riverside, CA.

Suicide Prevention Materials. Cherry Creek Schools, Milton W. Schmidt, Director of Institutional Services, 4700 S. Yosemite St., Englewood CO 80111. In-service an Resource Guide ($3.50). Student Curriculum Man al ($2.50). Intervention Training Manual ($3.00). Project Director's Manual ($6.00).

Suicide Prevention and Education Center, 982 Eastern Parkway, Suite 200, Louisville, KY 40217. Materials for school personnel and students (write for price).

Information Officer, Suicide Information and Education Centre, Suite 103, 732-14 St. NW, Calgary, Alberta T2N 2A4, Canada (write for price).

Help Hotline, P.O. Box 46, Youngstown, OH 44501. Teacher's curriculum and guide (Grades 9-12), $7.00.

Ann Arbor Publishers, Inc., P.O. Box 7249, Naples, FL 33941, "Preventing Teenage Suicide," $5.00.

Suicide Prevention Center, 184 Salem Ave., Dayton, OH 45406. Pamphlets: "Children and Suicide" ($.30), "Suicide and Youth" ($.25), "Suicide Prevention in Educational Settings" ($.30), "Adolescent Suicide School Project" ($.25), "Classroom Guide for Teachers (Jr. and Sr. High)" ($2.00).

FOOTNOTES

[1] Marv Miller, "Suicide Intervention," The Center for Information on Suicide, Suite 63, 6867 Golfcrest Dr., San Diego, CA 92119.

[2] *Suicide Surveillance*, Centers for Disease Control, Atlanta, Georgia, 1970-1980.

[3] Miller, p. 3.

[4] A. Lynch, *Redesigning School Health Services* (New York: Human Sciences Press, 1983), p. 92.

[5] J. Isherwood, K. S. Adam, and A. R. Hornblow, "Life Event Stress, Psychosocial Factors, Suicide Attempt and Auto-Accident Proclivity," *Psychosomatic Research*, vol. 2673 (1982), pp. 371-383.

[6] Miller, p. 3.

[7] J. Jurnovoy and D. Jenness, "Teenage Suicide," *Good Housekeeping* (January 1984), pp. 89-94; Catherine O'Neill, "No Tomorrow: Teen Suicide in America," *Washington Post*, Health Section (April 23, 1986), p. 15.

[8] Miller, p. 11.

[9] Adapted from Elaine Hals, "Suicide Prevention," *Health Education* (August/September 1985), pp. 45-47.

LETTERS

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and their peace-through-strength approach is seldom challenged by Christian ethics. As a result, the arms race consumes the best of mind and means.

In nuclear wars the question of combatancy and noncombatancy is largely irrelevant. With civilian populations being targeted, and the inadequacy of surviving medical services to treat civilian burn, blast, and radiation casualties, it is no longer as clear where a Christian serves his or her country best in time of war.

If we review the conflicts since the American Civil War, are we satisfied with the results of conscientious cooperation? Did medics help Hitler and Imperial Japan to brutalize their foes? Did conscientious cooperation also put Adventist medics from the U.S., Australia, and other countries into the Vietnam war to bolster the essential medical forces without which modern combat troops will not go into battle?

In reality, however, the most important question is not what to do in wartime but what attitudes we hold before wars break out. What message have SDA's been sending to government leaders? Have we encouraged them to seek military solutions, or have we suggested alternatives? Have we strongly upheld God's method of peace through justice and reconciliation? Do we consider matters of war and peace important in exercising our vote? Do we help to elect political representatives who are hawks or doves, who are nationalistic or who hold a broader worldview?

The high ethical ideals of Adventism should give us a unique enlightened view on many issues of war and peace. What is our attitude toward nuclear testing, the "Star Wars" proposal, and disarmament? As a church we have a great opportunity to exercise an international ethical responsibility. Just imagine the influence for good if Adventists told all political parties they would not vote for anyone with a "peace through strength" platform. Why has not this happened already? Perhaps our traditional views of noncombatancy, party political allegiance, and the divorce of Christian ethics from personal and political decision making are part of the problem.

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