PREVENTING ADOLESCENT SUICIDE

THE ROLE OF THE SCHOOL

Researchers estimate that up to 90 percent of those who commit suicide suffer from depression, other mental disorders, and/or substance abuse.

THE MEMORY IS STILL VIVID, EVEN after seven years. After finishing lunch, my husband and I sat in my office, happily discussing our plans to move back to Michigan. At that time, I was the chief of psychology services at a mid-size military hospital in the midwestern United States, having joined the Army four years before with the offer of a pre-doctoral clinical internship in psychology. Now that my commitment was almost complete, we were both excited about the upcoming changes in our lives.

Picture Removed

A few minutes later, my telephone rang. It was my aunt. As soon as I heard her voice, I knew something was wrong. She said simply, "Dora, I've got some bad news."

I said immediately, "It's Dad again—right, Judy?" He had struggled for years with a dual diagnosis of alcoholism and schizophrenia, and I braced for the worst—that he had had to be hospitalized again.

She said, "Yes, but the news this time is bad, Dora—really bad." She paused and cleared her voice before adding, "He's dead . . . He shot himself this morning."

I froze, then said in shock, "You're kidding, Judy, right?" But of course, she wasn't kidding. My father was gone.

The next few days were a blur. I remember crying, calling my sister to tell her the bad news, driving home to be with my mother, and lying awake at night. It was hard to put one foot in front of the other for the next several weeks. As I write this article, I remember it as if it were yesterday.

As a therapist and the chief of psychology services, I had worked with countless depressed and suicidal patients over the years. I had never lost a patient to suicide; and for the most part, my patients got better fairly quickly. I felt distressed that I hadn't been able to help my own father. But unfortunately, not only did he have two devastating conditions that continually fought against each other for control, but he also tended to shut out fam-

BY DORA D. CLARKE-PINE

ily members, including myself. Still, I couldn't help but wonder–If I had tried to interject myself into his life more firmly, more urgently, would things have worked out differently?

This article is about adolescent suicide, but I wanted to share the reality of my own experience. I hope that as you read this article, you will discard some of your own biases about suicide ("I know him . . . he would never do something like that" or "I work in a middle school, so I don't have to worry about suicide with students this young"), so that you can reach out more effectively to hurting students who may be contemplating suicide.

Risk Factors

The following factors increase the risk of suicide:

- previous suicidal behavior (attempts/gestures) and/or a current, concrete suicidal plan,
- a family history of suicidal acting-out behavior,
- current family-related problems and/or violence (e.g., physical/sexual abuse),
- a mental and/or substance-abuse problem or disorder such as depression and/or alcoholism,
- feelings of hopelessness,
- impulsive and/or aggressive behavioral patterns,
- a physical illness/condition,
- personal losses (relational/social, work-related, or financial),
- perceived or real barriers to mental-health treatment,
- access to guns and/or lethal drugs,
- feelings of isolation/alienation,
- an increased number of local suicides,
- cultural/religious beliefs that support suicidal behavior,
- suicidal behavior by significant others (e.g., friends, dating partners, etc.) and/or other notable figures (e.g., entertainers, rock musicians, etc.), and
- abnormal brain chemistry, such as diminished serotonin levels.[1]

Warning Signs

According to one estimate, approximately 70 percent of individuals who commit suicide are depressed.[2] Other researchers estimate that approximately 90 percent of those who commit suicide are experiencing depression or a substance abuse, and/or some other mental disorder.[3] The *good* news is that 80 percent of persons suffering from depression can be treated effectively—but unfortunately, only about 30 percent will actually seek help.[4]

When people are severely depressed, several symptoms appear over a two-week period. These symptoms can be summarized with an acronym that I have developed for teaching purposes: MIA=SiC MESS (the lower case "i" has been inserted). Thus, depressed individuals are currently "missing in action" because they are a "sick mess." Depressive symptoms include the following: (1) **M**ood changes (depressed and/or agitated), (2) decreased **I**nterest in things the person normally enjoyed, (3) **A**ppetite variations (increase or decrease), (4) **S**leep changes (insomnia—sleeplessness, or hypersomnia—sleeping too much), (5) problems with **C**oncentration and/or memory, (6) increased or decreased **M**otor activity; (7) lack of **E**nergy, (8) negative feelings of **S**elf-worth, and (9) **S**uicidal ideas or fixations on death-related themes.[5] Keeping this list in mind (MIA=SiC MESS) will improve your odds of recognizing the symptoms of depression in your students.

You should also be concerned if, along with displaying these symptoms, the person starts giving away valued possessions. He or she may be trying to "take care of business" before committing suicide. In addition, be wary of a sudden burst of optimism that does not accompany concrete, positive changes in the individual's life. It may be that he or she has decided to commit suicide and is no longer experiencing feelings of conflict.[6]

Picture Removed

The good news is that 80 percent of persons suffering from depression can be treated effectively—but unfortunately, only about 30 percent will actually seek help.

Suicide Prevention

The U.S. Surgeon General, in a recent call to action, noted that awareness, intervention, and methodology are important for any suicide-prevention program.[7] According to this report, *awareness* means increasing the public's understanding of suicide and its corresponding risk factors, *intervention* requires coordinating and expanding current services and programs, and *methodology* involves continued research on suicide and its prevention.[8]

Increased awareness. School personnel (teachers, administrators, office workers, nurses, custodians, work supervisors, etc.)

should be trained to recognize the visible signs pointing to increased suicidal risk.

Know your students. If you don't know your students well, obviously you will not be able to recognize "at-risk" behavioral changes when they occur. It is much easier to lose track of young people in large school systems and/or large classroom settings (e.g., classrooms of 25 students or more). Unfortunately, many schools are burdened with large classes. Last semester, in my university classes, I had approximately 150 students. About halfway through the semester, I had managed to memorize the names of almost all of them, but unfortunately, I became acquainted with only about 30 to 40 individuals on more than a first-name basis. Needless to say, if a teacher doesn't know a student by name, he or she probably will not recognize that student's pain or be able to reach out and help.

Peer involvement. A few mature students can serve as your eyes and ears in assessing problems with their peers, especially in larger school settings. There are countless stories of students who sensed something was wrong before a friend committed suicide, but didn't really know what, if anything, they should do with the information.

Accessibility to services. A school may have the most integrated and comprehensive programs available, but if the people running the programs are not approachable and respected, students will continue to fall between the cracks. Thus, school counselors, teachers, and administrators need to participate in informal school-related activities where they can get to know students personally. Such opportunities will help to foster trust and respect.

Risk action plan. In addition to ensuring accessibility to counselors and caring adults, every school system needs to have an action plan to deal with depressed or suicidal students. For example, when a teacher feels concerned about one of his or her students, the school counselor should be brought in to assess the situation. If there is no school counselor on staff, then other staff members—including school nurses, teachers, and administrators—need to know how to assess students who are "at-risk," as well as when to refer them for more in-depth mental health services.

The risk of suicide increases when a student not only expresses suicidal ideas, but also has a specific and concrete suicide plan, the means and ability to follow through with it (e.g., access to weapons or lethal pills, etc.), a highly lethal plan (e.g., use of a gun), and a history of previous and/or recent suicide attempts.

Informed Consent

Before exploring the areas described above, the school must obtain informed consent. School counselors should develop a form or brochure that outlines the overall purpose of counseling, the goals and techniques usually involved, the risks and benefits, the limitations of confidentiality, and other important information. Such a form can be signed by students as well as parents when appropriate. (Be sure to check parental consent laws, which vary from place to place.)[9] In schools that do not have a counselor on staff, it is important to consult with appropriate state agencies and/or professional school associations to determine appropriate procedures regarding confidentiality.

When people are severely depressed, several symptoms appear over a two-week period.

Picture Removed

The school counselor should do as thorough an assessment as possible. After confidentiality limitations are explained, he or she should gather information and use questions that would significantly decrease the student's tendency to lie. For example, when the counselor asks about alcohol abuse, he or she shouldn't say, "Have you ever used alcohol?" It's too easy for the student to say "No." Instead, the counselor can ask: "How much alcohol, in let's say a given week, do you typically consume—a six-pack, a bottle of wine?" If the client does consume alcohol, this allows the truth to surface more easily. If not, the person will probably say something like, "I don't drink and have never had an interest in doing so."

For child abuse, similar types of questions can be used. Instead of inquiring, "Have you ever been physically abused?" I generally ask questions like, "What's the most painful physical punishment you've ever received from your parents?" or "What's your worst memory growing up?"

Likewise, when seeking to diagnose depression and suicidal ideas, counselors need to ask street-wise questions. For example, the counselor could tell the student, "I believe you have considered suicide in the past. I'm just looking for the truth." He or she can then ask questions like, "When's the last time you thought of hurting yourself? What actions did you consider at that time?" rather than "Have you ever thought about hurting yourself?" Again, the latter question makes it much easier to say "No," and the truth may not come out. If the person has not contemplated suicide, he or she will reveal this fairly quickly. If the student has been having suicidal feelings, the school counselor needs to urge him or her to agree to a contract promising not to harm himself or herself. Failing this, hospitalization (voluntary or involuntary) is warranted.

If a student either reports suicidal thoughts or denies such thoughts, but the assigned school staff member conducting the assessment feels uncomfortable about the responses, then the student should immediately be referred for further evaluation by a mental-health provider. If the student will not sign a "no-harm" contract,

Picture Removed

then again a hospitalization (voluntary or involuntary) is warranted.

Parents will often need to be informed of their children's suicidal ideas, so that the family can take appropriate safety measures. For example, weapons may need to be removed from the home and lethal medications locked up. In addition, parents may need to become more actively involved in the counseling process. Indeed, it is important to keep in mind that "parents or guardians have the legal right to communication between the minor and the counselor."[10]

As with all assessments of "at-risk" students, when in doubt, school personnel should arrange an immediate consultation with a mental-health professional. Appropriate documentation should be kept regarding both school actions taken and consultations obtained.[11]

Coordination with community mental-health services. School counselors have numerous school-related duties besides crisis intervention, so if a student needs long-term follow-up, a community referral will probably be needed. The school must actively cooperate in this process. If school personnel recommend a self-help group, someone needs to ensure that, before a referral is made, the organization is checked out. It is a counselor's responsibility to ensure that the organization is not dysfunctional. Likewise, school counselors and staff members need to feel confident about the clinical competence/expertise of the counselors to whom they refer their students, because the first contact with a therapist can positively or negatively shape the person's perceptions about the entire idea of counseling.

Although establishing a referral base may initially seem overwhelming for school personnel, establishing contact with just one mental-health professional in the local community can often lead to other networking opportunities. Don't be afraid to ask a mental-health clinician to suggest other colleagues with a solid reputation of working successfully with troubled youth.

Encouraging parental involvement. To inform and involve parents, create and distribute brochures explaining school policy. Parents can also be encouraged to bring in policy concerns for discussion, after which necessary modifications to school policy can be made. Before making policy in sensitive areas, appoint a task force to advise school administrators. The task force should include school personnel, community mental-health professionals, law-enforcement officials, parents, and students.

Final Comments

According to the U.S. National Institute for Mental Health, suicide prevention should not focus on discussions of suicide and its risk factors. This may convince impressionable young people that suicidal thoughts are a normal reaction to stress. Instead, school personnel should focus on mental health and other early risk factors such as depression, substance abuse, and behavioral problems.[12] In addition, programs that seek to improve family and peer relationships (i.e., reducing peer conflict and tension), and enhance academic performance will be helpful.

It would be naive to think that we can eliminate suicidal behaviors from our school system, since we can never completely eliminate the risk factors (family-related turmoil, peer conflict, personal loss, loneliness/alienation, etc.). However, we can certainly work to more accurately recognize "at-risk" behavior and to find ways to reach out to young people who may be suffering in silence.[13]

Unfortunately, in a sinful world, losses will always occur. We need to remind students that God will sustain us through those times when it seems as if there is little or nothing to hold onto. He will never withdraw from us, and in time, our wounds will heal. One of my favorite verses is "Weeping may endure for a night, but joy cometh in the morning . . . Lord, by thy favour thou hast made my mountain to stand strong . . . to the end that my glory may sing praise to thee, and not be silent" (Psalm 30:5, 7, 12, KJV).

Despite the time that has passed since my

A few mature students can serve as your eyes and ears in assessing problems with their peers, especially in larger school settings.

Picture Removed

father's death and the limited access I had to him during his life, I still miss him terribly. It is especially tragic to lose a young person—someone with great promise whose whole life was still in front of him or her, due to a combination of perceived insurmountable stressors, a failure of adults and peers to recognize a young person's personal struggles, and/or an absence of accessible services for those who are suffering emotionally. Every school employee must take the time to get to know students enrolled in their institution, so that no one ever feels that alone.

***Dora D. Clarke-Pine** is an Associate Professor in the Education and Psychology Department at Southern Adventist University in Collegedale, Tennessee. She previously taught in the School of Education at La Sierra University in Riverside, California, and served as the Chief of Psychology services at a U.S. military hospital.*

REFERENCES

1. Steven E. Hyman, *Hearing on Suicide Awareness and Prevention* (Washington, D.C.: The National Institute of Mental Health before the Senate Appropriations Committee, 2000). See http://www.nimh.nih.gov/about/000208.cfm; National Institute of Mental Health (NIMH), *In Harm's Way: Suicide in America* (Bethesda, Md.: U.S. Government Printing Office, 1999). See http://www.nimh.nih.gov/publicat/harmaway.cfm; Nico Peruzzi and Bruce Bongar, "Assessing Risk for Completed Suicide in Patients With Major Depression: Psychologists' Views of Critical Factors," *Professional Psychology: Research and Practice* 30:6 (December 1999), pp. 576-580; U.S. Public Health Service (hereafter abbreviated as USPHS), *The Surgeon General's Call to Action to Prevent Suicide* (Washington, D.C.: U.S. Government Printing Office, 1999). See http://spanusa.org/calito~2.htm.

2. Peter C. Whybrow, Robert M. A. Hirschfeld, Jan Fawcett, Martin B. Keller, David Clark, Margaret Duthie, and Nancy Scheff, *Suicide Prevention and Depressive Disorders* (Chicago, Il.: National Depressive and Manic-Depressive Association, 1999). See http://www.ndmda.org/suicide.htm.

3. Hyman.

4. National Institute of Mental Health. *Depression Research at the National Institute of Mental Health: Fact Sheet* (NIH Publication No. 99-4501) (Bethesda, Md.: U.S. Government Printing Office, 1999). See http://www.nimh.nih.gov/publicat/depresfact.cfm; *No. 1 Cause of Suicide: Untreated Depression* (Minneapolis, Minn.: Suicide Awareness/Voices of Education, 1998). See http://www.save.org and www.save.org/symptoms.html.

5. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington, D.C.: 1994), p. 327.

6. Suicide Awareness/Voices of Education.

7. USPHS.

8. Ibid.

9. David M. Kaplan, *Developing an Informed Consent Brochure for Secondary Students* (Alexandria, Va.: American School Counselor Association, 2000). See http://www.schoolcounselor.org/ethics/informed.htm.

10. Robert L. Gibson and Marianne H. Mitchell, *Introduction to Counseling and Guidance* (Upper Saddle River, N.J.: Prentice-Hall, Inc., 1999), p. 447.

11. J. Jeffries McWhirter, B. T. McWhirter, A. M. McWhirter, and E. H. McWhirter, *At Risk Youth: A Comprehensive Response* (Pacific Grove, Calif.: Brooks/Cole Publishing, 1998).

12. Hyman.

13. Ibid.

Suicide Statistics

In the United States, suicide is the eighth leading cause of death overall. Surprisingly, suicides cause many more deaths than homicides. The elderly are most at risk for suicide because significant and painful losses seem to accumulate during the latter stages of life. But suicide is the third leading cause of death for ages 15 to 24, the fourth for ages 10 to 14, and the sixth for ages 5 to 14. Although suicide rates have remained fairly stable over the years in the U.S., between 1950 and 1990, adolescent suicide rates almost tripled.

Overall, women are three times more likely to attempt suicide than men, but men are four times more successful at completing the act. For adolescents, the gender ratio for successful suicides is five to one. Thus, males in general are much more at risk for successful suicides than are females (primarily because they tend to use more lethal means), but females are much more prone to such attempts. However, in countries where poison is often used in suicide attempts, and where poisons tend to be more lethal, females outnumber males in terms of successful suicides.

In the United States, when race and gender are examined simultaneously, the risks for successful suicide (in descending order) are as follows: Caucasian male, non-Caucasian male, Caucasian female, and non-Caucasian female.

Sources: American Association of Suicidology, U.S. Public Health Service, U.S. National Institute of Mental Health, and the American Academy of Child and Adolescent Psychiatry.