

## Chapter 7

# YOUTH SUICIDAL BEHAVIOR: A CRISIS IN NEED OF ATTENTION

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Suicide and suicidal behavior in children and adolescents has been at a crisis stage for the past two decades; however, it has only been recently that it is receiving some of the attention it truly deserves (Gould, Greenberg, Velting, & Shaffer, 2003; U.S. Department of Health and Human Services [DHHS], 2001). Using the most current data from 2001, suicide is currently the third leading cause of death in the United States for youth between the ages of 5 and 19 behind automobile accidents and homicide (Centers for Disease Control and Prevention [CDC], 2004). However, in some states, such as Washington, suicide is ranked second among 15- to 19-year-olds and twice that of the homicide rate (Washington State Youth Suicide Prevention Program, 2004).

### **SUICIDAL BEHAVIOR**

Unfortunately, suicide is only one behavior among a continuum of suicidal behaviors that consists of suicidal ideation at one end, followed by suicidal intent, then suicidal attempt(s), and finally death due to suicide, the far end of the continuum (Reynolds, 1988; Reynolds & Mazza, 1994). These stages or behaviors along the continuum are not independent, nor does every child or adolescent who is suicidal go through all four stages. As one moves up or along the suicidal behavior continuum, the prevalence of each behavior becomes less but increases in suicidal risk and/or lethality. According to the 2003 Youth Risk Behavior Survey (YRBS; CDC, 2004) completed by more than 15,000 high school students nationally, approximately one of out six high school adolescents (16.9%) stated they had thought seriously

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of attempting suicide, with a similar number (16.5%) stating that they had made a plan to attempt suicide. Regarding suicide attempts, approximately 1 out of 12 had made a suicide attempt in the past year, and 2.9% had made a suicide attempt that required medical attention (CDC, 2004).

### **Suicidal Ideation**

Suicidal ideation is at the beginning of the suicidal behavior continuum and is often viewed as the precursor to other more serious suicidal behaviors (DHHS, 2001; Ladame & Jeanneret, 1982; Mazza, in press; Reynolds, 1988; Reynolds & Mazza, 1994). Suicidal ideation consists of thoughts and cognitions about killing oneself as well as specific thoughts related to suicide. These thoughts and cognitions ranged from general thoughts about killing oneself or wishes of being dead or never being born to more specific and detailed thoughts, including a specific plan to kill oneself with the how, when, and where premeditated (Reynolds, 1988; Reynolds & Mazza, 1994).

In examining gender differences of suicidal ideation, females tend to be thinking about suicide more than males (CDC, 2004; Mazza & Reynolds, 2001; Reynolds, 1988). The results from the YRBS found that 21.3 percent of females had seriously considered attempting suicide within the past year compared to 12.8 percent for males (CDC, 2004). In using the Suicidal Ideation Questionnaire (Reynolds, 1987) to identify current suicidal ideation, Mazza and Reynolds (2001) found that 16 percent of females scored about the clinical cutoff score compared to 7 percent for males.

### **Suicidal Intent**

Suicidal intent is defined as the intentions of the individual at the time of their attempt in regard to their wish to die (Overholser & Spirito, 2003). Suicidal intent is made up of multiple components: expressed intent, planning, communication, and concealment (Kingsbury, 1993). Behaviors that represent these four components include but are not limited to giving away prized or meaningful possessions, writing a will, minor self-destructive behaviors, and subtle and/or overt threats (Reynolds, 1988). Several of these behaviors are overt and may be viewed as a warning sign to friends, family, and significant others that this specific individual is at risk for suicide and that follow-up regarding their current mental health is needed. It is important to note that not all suicidal youth engage in suicidal intent and, likewise, that not all youth who display these behaviors are suicidal.

### **Suicide Attempts**

Suicide attempts are self-injurious behaviors with the intentionality of causing death (Reynolds & Mazza, 1994). Research studies using

“psychological autopsies,” a method for collecting information about the deceased by interviewing friends and family members about the psychological well-being of the person who committed suicide (Shafii, Carrigan, Whittinghill, & Derrick, 1985), have found that those who died by suicide frequently engaged in prior suicidal behavior, including making multiple suicide attempts (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999). According to the CDC (2004), 1 of out 12 (8.5%) high school adolescents has attempted suicide within the past year (incidence rate). Research findings with middle school adolescents have shown slightly lower rates of 7.7 percent among sixth, seventh, and eighth graders (Reynolds & Mazza, 1999). With the incidence rate hovering around 7 to 8 percent for middle school and high school adolescents, the prevalence rate (lifetime) is considerably higher, ranging from 11 to 14 percent (Mazza & Reynolds, 2001; Riggs & Cheng, 1988), which means that approximately one out of eight to one out of seven high school adolescents attempts suicide before they graduate.

Similar to suicidal ideation, females engage in making a suicide attempt more frequently than males (Gould et al., 1998; Lewinsohn, Rohde, & Seeley, 1996; National Center for Health Statistics [NCHS], 2003; Reynolds & Mazza, 1993). According to the YRBS data, 11.5 percent of females made a suicide attempt in the past year compared to 5.4 percent for males, a ratio of approximately 2:1 (CDC, 2004). Reynolds and Mazza reported a similar 2:1 ratio in a sample of more than 3,400 school-based adolescents (469 suicide attempters) from eight different states. In addition, they found that among suicide attempters females were more likely to have made multiple attempts (35%) compared to males (22%). It should be noted that Garfinkel, Froese, and Hood (1982), who examined the medical records of 505 children and adolescents seen in an emergency room for a suicide attempt, found that most youth (78%) made low lethality attempts, compared to 21 percent of moderate lethality and only 1 percent of high lethality. These results, coupled with the fact that the majority of attempts made by these youth had a high likelihood of being rescued compared to 3.4 percent of low likelihood, suggests that most youth are ambivalent about taking their own lives (Garfinkel et al., 1982).

### **Suicide**

Suicide is defined as an intentional self-injurious behavior that resulted in death (Reynolds & Mazza, 1994). As stated previously, suicide is the third leading cause of death for youth ages 5 to 19 years old (CDC, 2004). Although suicide is the behavior that most frequently grabs the headlines, it is in fact the rarest of the suicidal behavior continuum. According to

the latest data (2001), the current rate of suicide is 7.9 per 100,000 for adolescents between the ages of 15 and 19 years and 1.3 per 100,000 for youth between the ages of 10 and 14 years (McIntosh, 2003). The suicide rate for youngsters ages five to nine is a bit more difficult to figure out for multiple reasons, but one primary explanation is that coroners are not likely to categorize a death as suicide unless intentional self-injury is proven, a difficult task among first through fourth graders.

In contrast to suicidal ideation and attempts, males die by suicide approximately five times more often than females (Anderson, 2002; NCHS, 2003). The reason for the large discrepancy in gender differences is twofold. First, males tend to use more lethal means to attempt suicide than females (Anderson, 2002; Reynolds & Mazza, 1993). Second, males are more likely to be substance abusers than females, and research has shown substance abuse to be linked with adolescent suicide (Shaffer et al., 1996; Shafii et al., 1985).

## **ETHNICITY**

The rate of adolescent suicide is not equally dispersed across the different ethnic groups. The highest rates of adolescent suicide are among Native Americans, while the lowest rate tends to be among Asian/Pacific Islanders (NCHS, 2003). Among the other large ethnic groups, Caucasians in general tend to have a higher rate than African Americans, who in turn have a higher rate than Latinos (NCHS, 2003). There are several factors that have been put forth to explain the high rate of suicide among Native Americans; these include a higher prevalence rate of owning firearms, high use of alcohol and/or drugs, and lack of social integration (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001).

## **METHODS**

Fortunately, the suicide attempt methods used by most children and adolescents tend to be of low lethality. As discussed previously in the Garfinkel et al. (1982) findings, children and adolescents tend to use methods of low lethality and allow for a high likelihood of being rescued (rescuability), suggesting that they are ambivalent about taking their own lives. This ambivalence is viewed as a protective factor and allows the youth time to change his or her mind and to seek help. According to the 469 adolescent suicide attempters in the Reynolds and Mazza (1993) study, the two most common methods for male and female adolescents were taking pills (22.5% and 45.1%, respectively) and cutting wrists (18.6% and 30.4%, respectively).

In contrast to adolescent suicide attempts, which are generally of low lethality and high rescuability, the most frequent method of suicide is guns, having high lethality and low rescuability (NCHS, 2003). Fifty-seven percent of all adolescent suicides were from guns, and firearms is the most common method used by both male and female adolescents who commit suicide (NCHS, 2004). Two studies showed that adolescents who died by suicide were three to four times more likely to have guns in their home compared to adolescents who attempted suicide and nonattempting psychiatric adolescents (Brent, Perper, Kolko, & Goldstein, 1988; Brent et al., 1991). Research from other countries has shown that limiting access to lethal means, such as guns or poisonous gases, has been an effective strategy in reducing suicide (DHHS, 2001; Krug, Powell, & Dahlbert, 1998), although further studies investigating this issue are needed.

### **Critical Issues in Youth Suicidal Behavior**

There are several critical issues that are important in helping one understand the complexity of youth suicidal behavior and to help facilitate the implementation of suicide prevention/intervention programs. Identifying warning signs and risk factors that are related to suicidal behavior is an important undertaking in providing accurate risk assessment and determining which strategies to use for intervention. In addition, dispelling myths surrounding adolescent suicidal behavior will provide clinicians and mental health professionals with confidence in working with youth at-risk for suicidal behavior and relieve some anxiety that school administrators have reported about implementing suicide prevention programs in their schools.

### **RISK FACTORS AND WARNING SIGNS**

There are a significant number of warning signs and risk factors that are related to suicide and suicidal behavior (Brent et al., 1999; Cole, 1989; Lewinsohn, Rohde, & Seeley, 1994; Mazza & Reynolds, 2001; Shafii, Stelta-Lenarsky, Derrick, Beckner, & Whittinghill, 1988). Research examining suicidal behavior in adolescents has focused on two specific at-risk populations: those who have died by suicide and those who have attempted suicide. Although these two behaviors are in close proximity on the suicidal behavior continuum, it is important to remember that these groups of adolescents are quite different; suicide attempters tend to be females, who make low-lethality attempts, while those who die by suicide tend to be males, who have made high-lethality attempts. Research studies using psychological autopsies for those who died by suicide and self-report questionnaires and clinical interviews for those who attempted

suicide have identified prior suicidal behavior, psychopathology, family history of suicidal behavior and/or psychopathology, and stressful life events (including physical and sexual abuse and relationship problems) as important risk factors and warning signs (Brent et al., 1999; Mazza & Reynolds, 2001; Shafii et al., 1988).

For adolescents, engaging in past suicidal behavior, particularly a past suicide attempt, is one of the strongest predictors of future suicidal behavior (Brent et al., 1999; Groholt, Ekeberg, Wichstrom, & Haldorsen, 1997; McKeown et al., 1998). Groholt and colleagues, who studied children and adolescents who died by suicide, reported that one-fourth to one-third had a history of making a prior suicide attempt. Shaffer and colleagues (1996) reported among children and adolescents who died by suicide that a prior suicide attempt was more predictive for boys than for girls.

A previous history of suicide in the family and/or psychopathology is an important risk factor for adolescent suicidal behavior (Brent, Bridge, Johnson, & Connolly, 1996; Johnson, Brent, Bridge, & Connolly, 1998; Shafii et al., 1985). Based on the results from the studies cited previously, a family history of suicidal behavior significantly increases the likelihood of youth engaging in suicidal behavior. In addition, family history of psychopathology, such as depression, also increases the likelihood of youth suicidal behavior even when the family history of suicidal behavior is negative (Brent et al., 1996). Because some psychopathology has been found to be genetic and these illnesses may include suicidal behavior as part of their symptomatology (i.e., depression, anxiety, and schizophrenia), obtaining a thorough family history becomes an important factor in helping assess and intervene with at-risk youth (Hollenbeck, Dyl, & Spirito, 2003).

Another important risk factor for youth who engage in suicidal behavior is psychopathology (Brent et al., 1999; Marttunen, Aro, & Lonnqvist, 1991; Shafii et al., 1988). Shafii and colleagues (1988), using psychological autopsies, reported that more than 90 percent of youth who died by suicide had at least one psychiatric disorder, such as depression, substance abuse, conduct disorder, and antisocial personality disorder. In fact, most adolescents who have committed suicide have multiple psychiatric disorders occurring simultaneously, a phenomenon called comorbidity (Shafii et al., 1988). The substantial presence of psychopathology and often comorbidity indicates that suicidal behavior does not happen in isolation but rather is related to other mental health difficulties. Depression is the most common psychopathology linked to suicidal behavior, with approximately 50 to 66 percent of those who died by suicide experiencing some type of depressive disorder (Marttunen et al., 1991; Shaffer et al., 1996). However, it is important to note that not all youth who are depressed are suicidal and, likewise, that not all suicidal youth are depressed (Reynolds & Mazza, 1993). Research

results from other studies have also identified substance abuse, anxiety disorders, schizophrenia, borderline personality disorder, and adjustment disorder as being related to adolescent suicidal behavior (Brent et al., 1999, Marttunen et al., 1991; Mazza & Reynolds, 2001; Shafii et al., 1988). One important mental health problem is hopelessness, and although it is not a diagnosis in itself, several studies have shown that it is uniquely related to suicidal behavior in adolescents, especially among females (Cole, 1989; Mazza & Reynolds, 1998).

Stressful life events is the last risk factor mentioned in this chapter, although there are many others beyond the few named here. The stress-causing event can happen either to the adolescent or to his or her family. For example, research conducted by Marttunen and colleagues reported events such as parent's divorce, breakup of a romantic relationship, disciplinary or legal action, academic failure, and death of a loved one as being significantly related to youth suicidal behavior (Marttunen, Aro, & Lonnqvist, 1993). In addition, youth who experience physical and/or sexual abuse have been also shown to have higher rates of suicide and attempted suicide compared to peers who have not been abused (Johnson et al., 2002; Silverman, Reinherz, & Giaconai, 1996). However, determining the unique relationship of physical and/or sexual abuse regarding youth suicidal behavior is complicated because frequently the abusive behaviors are accompanied by other risk factors as well, such as family and/or individual psychopathology.

## MYTHS

Dispelling myths surrounding youth suicidal behavior is important, so clinicians and mental health workers can feel confident in the questions they ask and the strategies they implement. In addition, these myths have been a barrier for parents and school administrators when talking to their children regarding issues related to suicidal behavior. One of the biggest myths is the belief that talking about suicide will cause or give youth ideas about suicide (Kalafat, 2003; Reynolds, 1988). Unfortunately, this myth is held by many parents, school administrators, school counselors, and mental health workers. Actually, talking about suicide and suicidal behavior with a trusted adult allows youth the opportunity to ask questions and share their feelings about themselves or someone else who may be at risk. The issues of suicidal behavior are frequently on the minds of youth, and there is a high probability that many students know someone who has died by or attempted suicide. Given that most adults are uncomfortable talking about suicidal behavior and the taboo surrounding the subject, providing a bridge of communication that is nonjudgmental is a proactive approach in helping students discuss their beliefs, feelings, and misperceptions. Proactive approaches, such as

screening youth for suicidal behavior, have been recommended by the U.S. surgeon general as a primary care strategy (DHHS, 2001).

The second myth regarding suicidal behavior is that those who attempt suicide typically get medical treatment (Smith & Crawford, 1986). Unfortunately, most youth do not tell their parents about their suicide attempts. In a study of 313 adolescent suicide attempters, Smith and Crawford reported that only 12 percent received medical treatment for their attempt, leaving 88 percent untreated. One facet of this behavior is that most youth are not old enough to drive, nor are their friends; thus, transportation for medical treatment would require telling an older sibling or parent about their behavior, an approach that most adolescents do not take.

A third myth is in regard to youth leaving suicide notes if they are suicidal (Garfinkel et al., 1982; Leenaars, 1992). Garfinkel and colleagues (1982) found that only 5 percent of children and adolescents wrote a suicide note before their suicide attempt. Similar to the medical treatment myth, one of the primary reasons they do not write a suicide note is that they do not want their parents finding out what they are thinking or feeling. Adolescents often feel that parents are overly involved or interfering in their lives and that writing a suicide note only increases the likelihood of getting parents more involved.

The last myth surrounds parents' knowledge of their child's suicidal behavior. It is a myth that parents know if their child is suicidal (Kashani, Goddard, & Reid, 1989). The Kashani et al. study found that 86 percent of parents were unaware of their child's suicidal behavior, including suicide attempts. Again, similar to several other myths, adolescents do not communicate their suicidal thinking or behavior to their parents. The importance of this finding is that clinicians, school counselors and psychologists, and youth mental health workers need to ask the youth themselves directly regarding suicidal behavior rather than relying on parents for this information. Remember the first myth: asking about suicidal behavior does not cause or give ideas to youth. Thus, direct questioning regarding suicide is a proactive strategy.

## **SUMMARY OF BACKGROUND INFORMATION**

Thus far, this chapter has provided some background information regarding the different types of suicidal behavior, their definitions, and facts regarding the frequency of each. However, it should be noted that the agreement of standardized nomenclature regarding the definitions of suicidal behaviors remains a contentious issue for researchers and clinicians (Berman & Jobes, 1991). In addition, the previous sections highlighted descriptive information, risk factors, and warning signs and dispelled several myths that are



potential barriers for helping mental health professional in working with at-risk youth. It is hoped that the information given thus far has provided a foundational level of knowledge for the subsequent sections.

### **A Crisis in Need of Attention**

Suicidal behavior in youth has been a crisis in need of attention for the past 20 years. The suicide rate for adolescents ages 15 to 19 years tripled from 1955 to 1994 to a rate of 11.2 per 100,000 but has been slowly declining over the past 10 years to its current level of 7.9 per 100,000 (McIntosh, 2003; NCHS, 2003). The rate of increase over the past 25 years for younger adolescents ages 10 to 14 years has been equally alarming. According to the CDC, the suicide rate for 10- to 14-year-olds increased 99 percent from 1980 to 1997 compared to 11 percent for 15- to 19-year-olds during the same period (McIntosh, 2003). Within the past five years, the U.S. surgeon general has recognized this crisis and provided two important documents: "The Surgeon General's Call to Action to Prevent Suicide" and the "National Strategy for Suicide Prevention: Goals and Objectives for Action" (DHHS, 2001; U.S. Public Health Service, 1999). Although these two documents emphasize the problem of suicide in our society in general, they specifically highlight the problem in youth suicide and provide a structure for developing broad-based support systems in communities, workplaces, and schools. In addition, the national strategy calls for the development and implementation of suicide prevention programs that are evidenced based in preventing and/or reducing suicidal behavior in schools, universities, and other environments (DHHS, 2001).

### **SCHOOL-BASED PREVENTION PROGRAMS**

Middle schools and high schools are an ideal place to implement suicide prevention programs. Although a majority of the students at these institutions are not at risk for suicidal behavior, implementing programs at these institutions would maximize the identification of youth who are at risk. Given the myths that were highlighted previously, it is unlikely that teachers, school administrators, and/or parents know if their students or child is at risk for suicidal behavior. In addition, goal 4.2 of the U.S. surgeon general's National Strategy for Suicide Prevention highlighted the need to develop evidence-based suicide prevention programs for schools, universities, and other facilities, while goal 7.2 emphasized the need to incorporate suicide risk screening to identify those at risk for suicide (DHHS, 2001). However, the development and implementation of suicide prevention programs, especially in the school environment, involves

numerous factors and resources (Kalafat, 2003). In addition, some suicide prevention programs focus on helping adolescents stay in school, based on research that shows higher rates of suicidal behavior in youth who are at risk for dropping out of school (Eggert, Nicholas, & Owens, 1995; Eggert, Thompson, Herting, & Nicholas, 1995).

One of the first steps is to identify what has been done in the past, what has worked, and what has not worked. Garland, Shaffer, and Whittle (1989) reviewed 115 suicide prevention programs that were designed for youth and developed in the early to mid-1980s. Results of their review found that many programs were problematic with short duration (two hours or less), had subscribed to a stress-model theoretical orientation, and focused on goals of educating staff and students about youth suicidal behavior and raising awareness of the problem. Mazza's (1997) review of 11 school-based suicide prevention programs from 1980 to 1994 found similar problematic structures and was critical of programs not providing empirical support showing the efficacy of their programs in regard to suicidal behavior themselves. Many of the first-generation programs (Kalafat, 2003), those developed in the 1980s and early 1990s, failed to identify their intended audience, lacked clear goals, and provided mixed results (Ciffone, 1993; Kalafat & Elias, 1994; Overholser, Hemstreet, Spirito, & Vyse, 1989; Shaffer, Garland, Gould, Fisher, & Trautman, 1988). With increased research in this area and reviews of multiple programs, several major components were identified that needed to change.

First, Garland and colleagues (1989) reported that 96 percent of the programs they reviewed used a stress-model theoretical orientation. This was quite problematic because it provided the message that anyone could become suicidal if under enough stress. In addition, this theoretical orientation ignored the significant amount of research that links suicidal behavior to psychopathology (Brent et al., 1999; Marttunen et al., 1991; Shaffer et al., 1996). Thus, it was recommended that suicide prevention programs use an empirical-based theoretical orientation, such as mental illness or psychopathology, rather than a stress-related model (DHHS, 2001).

Second, prevention programs were of short duration, ranging from several hours to several days, and were not linked to the education curriculum (Garland et al., 1989). Programs that are implemented in isolation and are not part of a larger school curriculum frequently are viewed as inefficient, strain school resources, and are not well supported. Thus, suicide prevention programs have been recommended to be consistent with school culture, utilize school resources efficiently, and comply with school mandates (Kalafat, 2003).

Third, the goals of most prevention programs were to enhance knowledge of staff and students regarding youth suicidal behavior, change attitudes

about seeking help for oneself or a friend who may be at risk for suicide, and raise awareness of the problem of youth suicide (Garland et al., 1989; Mazza, 1997). Although these goals centered on important behaviors within a suicide prevention curriculum, they do not focus on reducing suicidal behavior itself. Thus, when programs provided data on effectiveness in reaching their intended goals, many programs were deemed effective without measuring actual changes in suicidal behavior. Unfortunately, increases in knowledge and attitude changes have not resulted in substantial changes in suicidal behavior (Berman & Jobes, 1995; Ciffone, 1993). Furthermore, although suicide itself has a low-base rate, several other behaviors along the continuum, such as suicidal ideation or suicide attempts, happen at a great enough frequency that they could be used as dependent measures for evaluating program effectiveness (Mazza, 1997; Potter, Powell, & Kachur, 1995). Thus, the implementation of efficacy measures that examine actual suicidal behavior has been recommended as part of the program effectiveness evaluation for second-generation programs (Konick, Brandt, & Gutierrez, 2002; Mazza, 1997; Potter et al., 1995).

This leads to the fourth change, which is program evaluation design. Second-generation evaluation of programs need to not only measure actual suicidal behavior but also provide multiple evaluation periods that examine the short-term and long-term impact of their prevention programs. Most of the first-generation programs used a pretest-posttest design (Ciffone, 1993; Kalafat & Elias, 1994; Overholser et al., 1989; Shaffer, Garland, Vieland, Underwood, & Busner, 1991), and when examining knowledge gains and attitude changes, this design/approach makes logical sense. However, short-term and long-term follow-up are recommended to determine the short- and long-term impact of the program after it has been implemented (Kalafat, 2003; Mazza, 1997). This is especially important when examining suicidal behavior, as it allows time to pass and provides multiple opportunities for students to implement program strategies or procedures and, conversely, for suicidal behavior to occur.

The last component that needs revision is the intended target audience. As stated earlier, many of the first-generation programs were implemented, but it was unclear if they were intended for at-risk suicidal students, friends of those who might be at risk, all students, or school staff (Garland et al., 1989; Kalafat, 2003). Implementing a unilateral approach to address the needs of those who are at risk for suicidal behavior as well as those who are not and trying to educate students, staff, and school administrators at the same time does not work (Kalafat, 2003). Because students have diverse needs regarding mental health and specifically suicidal behavior, it is recommended that school-based suicide prevention programs be multifaceted in addressing the needs of students of varying degrees of risk,

staff, administrators, and other caring adults, such as parents and coaches. In addition, second-generation programs need to span beyond the school environment and involve community, parents, and other mental health professionals in order to be successful. For example, once a student is identified as high risk for suicide, most school counselors or psychologists are not trained to provide clinical services to this student; thus, linking with trained community professionals in this case is essential. Likewise, providing opportunities for student involvement in the development and delivery of the program has been shown to be effective as well (Eastgard, 2000) because most suicidal youth confide in their peers rather than adults (Brent et al., 1988; Kalafat & Elias, 1992), and peer-to-peer messages are sometimes more effective than teacher-to-peer messages.

Determining the audience for school-based suicide prevention programs is more complex than it seems, and a one-size-fits-all approach does not work (Kalafat, 2003). The Institute of Medicine has three categories for describing the audiences who receive treatment or intervention/prevention programs:

- a) "Universal" programs are intended for everyone or the general audience. For schools, this would include all students as well as teachers, school counselors, administrators, and other adults who are in close contact with students. Specific to suicide prevention programs, universal programs include increasing awareness of youth suicidal behavior, identifying warning signs, teaching appropriate responses to peers who may come in contact with someone who is suicidal, and identifying youth who may be at risk for suicide (Kalafat, 2003). In addition, school procedures and policies for intervention with suicidal youth are also included in universal programs. Most suicide prevention programs target universal populations (Kalafat & Elias, 1994; Overholser et al., 1989; Shaffer et al., 1991).
- b) "Selective" programs target those subpopulations that are at greater risk because of predetermined risk factors that have been linked to suicidal behavior through previous research. In this case, adolescents with psychopathology, youth in transition between middle and high school and between high school and higher education, and those who have a history of suicidal behavior in their family would be targeted. Components of a selective program may include developing and teaching coping strategies and skills, identifying different community and school resources to get help, coaching and practicing help-seeking behavior, highlighting peer involvement and how to respond to someone who may be suicidal, and identifying youth who have already engaged in past or are currently engaging in suicidal behavior. In contrast to universal programs, there are no selective suicide prevention programs to date, at least none that have appeared in the suicidology literature base (Kalafat, 2003). One could argue that being an adolescent in general is a subpopulation at

risk, given the high prevalence of alcohol and drug use among teens, the transition from grade 8 to grade 9 and again after grade 12, and the change in social support, coupled with the biological changes that are related to numerous psychopathologies. Perhaps most programs in middle and high school are actually "selective universal" suicide prevention programs.

- c) "Indicated" programs target a subpopulation that has already been identified as being at risk through screening, usually indicating past or current suicidal behavior, peer or self-referral, or other identification process. Indicated programs focus on helping to resolve the current conflicts or crises and aim to reduce the risk of engaging in more suicidal behavior. Components of an indicated prevention program include developing and teaching adaptive coping strategies that help youth deal with stress and emotional dysregulation; understanding how to access emergency help; providing ongoing support during crisis or emotional times; learning to cope with mental health problems and their relationship to suicidal behavior; identifying caring adults in school, home, and community environments; and learning how to talk about their feelings. There is one indicated program that has provided empirical data regarding the effectiveness of their program called Reconnecting Youth (RY) (Eggert, Nicholas, et al., 1995). This program identifies students who are at risk for school dropout and places them in one of two groups: RY class or controls. Result from this indicated prevention program showed that students who received the RY class engaged in less suicidal behavior than controls (Eggert, Thompson, et al., 1995). Subsequent work using shorter intervention programs have been also shown to be effective in reducing suicidal ideation and attitudes among high-risk adolescents (Randell, Eggert, & Pike, 2001; Thompson, Eggert, Randell, & Pike, 2001). One interesting finding to note was that simply conducting a brief assessment interview showed a reduction in suicidal risk behavior, suggesting that assessment alone may act as an intervention because it allowed students to talk to an adult who simply wanted to know how he or she felt.

There are strengths and challenges to each type of suicide prevention program as there are for each school district and individual school. The program that may fit the best for one school may be the least favorite for another. It is important to view the universal, selective, and indicated programs as complementary rather than competitively. This type of complementary intervention would address the needs of those who have engaged in past and/or current suicidal behavior (indicated) while fulfilling the role of educating nonsuicidal students, school staff, and administrators about the risk factors, warning signs, facts, and myths surrounding youth suicide.

It is important to remember that the development, implementation, and evaluation of school-based suicide prevention programs is an iterative process (Kalafat, 2003). Of equal importance is the ongoing systematic

process of evaluating current programs and making revisions where possible and developing new third-generation programs that utilize the strengths of past programs. The first-generation programs, although far from perfect, provided important stepping-stones in developing and implementing more effective second-generation programs. There are several second-generation programs that have addressed the needs of the students, at risk and not at risk for suicide, and have spanned across school, community, and home environments (Kalafat, 2003). The first program, called Lifelines ASAP (Kalafat, Ryerson, & Underwood, 2001), was implemented in New Jersey, and the second one, called Suicide Prevention and School Crisis Management Program (Zenere & Lazarus, 1997), was implemented in Florida. Long-term follow-up results, 10 years and 6 years, respectively, have shown a reduction in youth suicides in those counties where the programs were implemented that was not evident in these states or nationally during the same time period (Kalafat, 2003). With successful programs such as these, it is hoped that second-generation programs will in turn inform third-generation programs and so on, with the goal to develop and implement suicide prevention programs that meet the needs of all students through education, identification, and treatment in a seamless environment across school, community, and home.

## **PSYCHOTHERAPY TREATMENTS**

There have been numerous types of psychotherapy approaches used with children and adolescents, including psychoanalytic, cognitive-behavioral, dialectical behavior, group therapies, and family-focused interventions (Gutstein & Rudd, 1990; Lewinsohn et al., 1996; Miller Rathus, Linehan, Wetzler, & Leigh, 1997; Ottino, 1999; Ross & Motto, 1984; Rotheram-Borus, Piacentini, Miller, Graae, & Castro-Blanco, 1994). Unfortunately, researchers rarely collected any systematic empirical data that examined the outcome of the therapeutic intervention on actual suicidal behavior. Outcomes from these therapeutic approaches were often measured by reduced hospitalization visits, reduction in related psychopathology severity (i.e., depression), and increased family support (Greenfield, Hechtman, & Trembaly, 1995; Gutstein & Rudd, 1990; Millet et al., 1997). There have been a few randomized trials (treatment versus controls—with regard to suicidal behavior it is usually standard care) examining the treatment effects of different interventions among suicidal adolescents (Cotgrove, Zirinsky, Black, & Weston, 1995; Harrington et al., 1998; Rudd et al., 1996). The results from these studies do not provide clear support for any of the different treatment approaches. Several studies failed to show that their approach was significantly better than the standard care. A study

by Harrington et al. (1998) did show that adolescents who had attempted suicide but were not depressed had lower levels of suicidal ideation during the six months of follow-up compared to controls; however, the number of suicide attempts after treatment were similar for both groups.

It is important to note one psychotherapy treatment that has shown consistent results in reducing suicidal behavior among adults, particularly women, called Dialectical Behavior Therapy (DBT; Linehan, 1993). Dialectical behavior therapy is a specific type of cognitive-behavioral therapy that focuses on clients' suicidal behavior as a result of emotional dysregulation (Linehan, 1993). There are four sets of skills targeted in DBT: mindfulness, distress-tolerance, emotional regulation, and interpersonal effectiveness. Randomized control studies have shown that clients receiving DBT had substantially fewer suicide attempts during treatment and follow-up and fewer hospitalizations due to suicidal behavior than clients who were placed in the control group (treatment as usual). These strong results have prompted others (Miller, 1999; Miller et al., 1997) to incorporate and utilize these skills in working with suicidal youth. To date, however, this author is unaware of any randomized trials examining the reduction of suicidal behavior in youth using DBT.

## PSYCHOPHARMACOLOGY

The issue of using psychopharmacological treatment among suicidal youth has come under strong scrutiny lately because of the recent findings that some of the most popular antidepressant drugs (i.e., Prozac and Paxil) may increase the risk of suicidal behavior among youth (Richwine, 2004). Several selective serotonin reuptake inhibitors (SSRIs) have been banned in the United Kingdom, including Paxil and Effexor, for use with children and adolescents (Alliance for Human Research Protection [AHRP], 2004). The only SSRI not banned by the United Kingdom is Prozac, which has received approval for use in children who suffer from depression (AHRP, 2004). In the United States, the Food and Drug Administration (FDA) advisory panel recently suggested that all SSRIs carry a "black box warning" on their labels stating that these drugs can cause suicidal behavior in children (Elias, 2004). The FDA frequently follows the suggestions of the FDA advisory panel. The FDA officials stated that approximately 2 to 3 percent of children on the SSRIs became more suicidal because of the drugs (Elias, 2004). Although banning drugs or providing warning labels seems like an easy fix to the problem, the flip side is that many physicians may be hesitant to prescribe antidepressants to children and adolescent for other types of mental health problems even if warranted. Remember, psychopathology is one of the key risk factors associated with youth suicidal behavior. The

controversy surrounding antidepressants (more specifically SSRIs) will not go away soon; however, raising the public's awareness of the challenges and strengths of psychopharmacological treatments is important for those who prescribe these medications as well as for those whom the medication is prescribed.

## HOW CAN I MAKE A DIFFERENCE?

Making a difference to a youth who is suicidal does not require expert training in suicidology, a clinical degree in child and adolescent psychology, or a degree in pediatric medicine. It is important, however, that one recognize his or her limitations and to keep in mind that the ultimate goal in talking to someone who is thinking about suicide is to get him or her to an adult who has professional training in the area of youth suicidal behavior. The Washington State Youth Suicide Prevention Program (2004) suggests three simple but very important steps in talking to someone who is thinking about suicide:

1. Show you care: I am concerned about you and how you are feeling.
2. Ask the question, Are you thinking about suicide? or Are you thinking about killing yourself?
3. Get help from an adult: I know where we can get help.

The first step is key and needs to be done with care and concern to establish a trusting relationship that will allow for a smooth transition into steps 2 and 3. Step 1 is designed to show the youth that you are willing to listen to his or her problems or feelings. It is important that this is done in a nonjudgmental way and that you do not negate the severity of the problem the youth is experiencing. Negating statements such as "everything will be better soon," "that is not a big problem," and "you have so much going for you" should be avoided, as they are often viewed as dismissing. It is often hard for youth to talk to an adult because they feel that adults do not listen to them and minimize the importance of significant issues that are on their minds. Thus, showing that you care and being a good listener will help youth feel more comfortable in talking about their true feelings.

The second step, asking the youth directly if they are thinking about suicide, seems to be the hardest for adults. Although distraught youth feel this question is a natural follow-up from what has been said in response to step 1, many adults feel that asking about suicide is too abrasive or personal. Nonetheless, it is an appropriate question and is an extension of step 1, showing concern and listening. If the youth responds "yes" in



step 2, don't panic and keep listening intently with the ultimate goal being to get this youngster to an adult who has professional training or knows someone who can access the professional help, which is step 3. If the youth says "no" or "of course I would never do that," simply let him or her know that you are glad and that sometimes youth who are struggling with various issues think about these things but that there are always better strategies than suicide.

Step 3 is getting the youth to a trained professional in the area of youth suicidal behavior or getting him or her connected to someone who can contact the appropriate professional resources. In school settings, school psychologists and school counselors are often the contact person who has the referral list of mental health workers or clinicians who specialize in the area of youth suicidal behavior. As the adult who conducted steps 1 and 2, it is important that you facilitate step 3 to the professional or to the resource person. The transition to another adult whom the youth may not know or feel comfortable with is important so that the youth does not feel abandoned or passed off to someone else. If you identify someone who is at risk for suicide, it is important that caring adults from the school, home, and community environments be identified and in close contact with each other to make sure the youth is safe and being monitored.

## **SUMMARY**

This chapter provided an overview of youth suicidal behavior and the issues surrounding the field today. As can be seen from the chapter, youth suicidal behavior is quite complex and is indeed a crisis that needs to be addressed across multiple environments: school, community, and home. It is only through collaborative efforts, resources, and support that we can make an impact on helping reduce the rate of youth suicide and provide appropriate services for those who are thinking about or who have engaged in suicidal behavior.

## **RESOURCES FOR YOUTH SUICIDE**

Here is a list of important resources to contact regarding information about youth suicide:

1. 1 800-273-TALK—National Suicide Crisis line in case of an emergency
2. American Association of Suicidology (<http://www.suicidology.org>)
3. American Foundation of Suicide Prevention (<http://www.afsp.org>)
4. Centers for Disease Control and Prevention (<http://www.cdc.gov>)

5. Suicide Prevention Resource Center (<http://www.sprc.org>)
6. Substance Abuse and Mental Health Service Administration (<http://www.samhsa.gov>)

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