

Practical Strategies for Preventing Adolescent Suicide

By Keith A. King, Ph.D., C.H.E.S.

Suicide currently ranks as the 11th leading cause of death in the U.S. (Kochanek et al., 2004) with greater than 31,000 individuals dying each year due to suicide. In 2002, the year with the most recent mortality statistics, there were 31,655 suicides resulting in a national rate of 11.0 per 100,000 and equating to one suicide every 16.6 minutes. Specifically regarding youth, suicide is the third leading cause of death among 15- to 24-year-olds, exceeded only by injuries and homicides (Kochanek et al., 2004). In 2002, the suicide rate of this age group was 9.9 per 100,000, totaling 4,010 suicides or 11 suicides each day. There were also 260 suicides among 10- to 14-year-olds in 2001. Every 2 hours and 3 minutes a young person under the age of 25 killed him or herself (McIntosh, 2002).

From the 1950s to the mid-1990s, the suicide rate for adolescents more than tripled while the rate for the overall population remained virtually unchanged (Hoyert, Kochanek, & Murphy, 1999). A typical high school classroom includes one boy and two girls who attempted suicide in the past year (King, 1997). Data from the 2005 Youth Risk Behavior Survey (Eaton et al., 2006) revealed that during the 12 months preceding the survey: 28.5% of high school students had felt so sad or hopeless almost every day for at least 2 weeks in a row that they stopped doing some usual activities, 16.9% of high school students had seriously considered attempting suicide, 13% of high school students had made a plan to attempt suicide, 8.4% of high school students had actually attempted suicide one or more times, and 2.3% of high school students had made a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.

Further heightening the problem is the fact that youth suicide is greatly underreported due to inaccurate death classifications (Capuzzi & Golden, 1988). Estimates of official underreporting of suicide by medical examiners have ranged from 25% to 50% (Jobes, Casey, Berman, & Wright, 1991; Rosenberg et al., 1988). Researchers estimate that for each completed youth suicide, there are approximately 100 to 200 suicide attempts (National Center for Health Statistics, 1992; Blumenthal, 1990), resulting in more than 80,000 attempts each year.

Clearly, more attention and effort needs to be devoted to youth suicide prevention. Recognizing this issue, the 105th U.S. Congress declared suicide prevention a national priority. In turn, the U.S. Surgeon General issued a Call to Action to Prevent Suicide reiterating the urgency to treat suicide as a serious public health problem (U.S. Public Health Service, 1999). On October 21, 2004, President Bush signed into law the Garrett Lee Smith Memorial Act (PL 108-355) which enables states, Indian tribes, colleges and universities to develop suicide prevention and intervention



programs. This act also acknowledges the significant toll that mental disorders can have on college students' abilities to succeed in school. Such efforts have helped to increase community awareness of suicide as a major problem in this country. However there are still far too many young individuals attempting and completing suicide.

The Three Levels of Suicide Prevention

In order to most effectively address adolescent suicide, agencies, facilities and institutions that serve adolescents should develop and implement a comprehensive suicide prevention program. This program should consist of three levels: 1) Prevention (primary prevention); 2) Intervention (secondary prevention); and 3) Postvention (tertiary prevention). *Prevention* refers to programs, activities, and efforts aimed at decreasing youth suicidal thoughts, attempts, and completions. These efforts should focus on building protective factors in youth and raising staff and youth awareness of suicide warning signs, risk factors, and referral steps. *Intervention* refers to the steps professionals should take when an adolescent threatens or attempts suicide. When an adolescent makes a suicidal threat, it is critical that professionals follow the steps

Youth suicide is greatly underreported due to inaccurate death classifications.

outlined in the agency suicide intervention plan. Intervention steps should focus on securing the surrounding area, maintaining safety,

referring the suicidal youth to a mental health professional and immediately following up to ensure that the needed help has been received. All staff members should be familiar with the appropriate steps to take when a student threatens suicide. *Postvention* refers to the appropriate activities that should occur after an adolescent has attempted or completed suicide. Since suicide clusters and potential copycat suicides are well established among adolescents, the agency/facility response to an actual suicide is crucial (Leenaars & Wenckstern, 1998). The goal of postvention is to minimize the trauma to youth at the agency or facility and reduce the likelihood of possible copycat suicides. The following paragraphs outline specific strategies that professionals can employ to effectively prevent adolescent suicide at all three levels.

Prevention Strategies

Build Protective Factors and Positive Connections

Adolescent suicides can effectively be averted by building protective factors and developing positive connections in youth. The National

Longitudinal Study on Adolescent Health (Resnick et al., 1997) found that the leading protective factor against adolescent suicide was a sense of family and school connectedness. Adolescents who felt positively connected to their family and school were significantly less likely than adolescents who did not feel positively connected to have seriously considered or attempted suicide in the past year. Adults working with youth should take note of this finding and in turn seek to develop positive connections with young people by remaining emotionally supportive, encouraging, caring, and receptive. Such steps can be achieved by actively listening, setting high but obtainable expectations, working with young people to achieve set goals, responding to concerns, and encouraging communication of emotions and feelings.

Additional factors protecting youth from suicide include effective coping skills, positive peer groups, conflict resolution skills, high levels of self-esteem, academic achievement, and opportunities for participation in meaningful activities (World Health Organization, 2000).

Increase Knowledge of Suicidal Warning Signs

Research indicates that approximately 9 in 10 youth who are suicidal offer clues or show warning signs that can be detected by others (Hicks, 1990). Individuals working with adolescents should familiarize themselves with the warning signs of suicide and be comfortable with identifying them in youth. Unfortunately, many professionals do not know or recognize the warning signs and risk factors and therefore miss the opportunity to appropriately identify adolescents who may be considering suicide. Recent studies have shown that only 1 in 11 (9%) high school teachers and 1 in 3 (33%) high school counselors feel confident in their abilities to identify students at risk for suicide (King et al., 1999a, 1999b). All individuals who work with youth should be knowledgeable about the warning signs, so that at-risk youth can be more quickly identified and receive the help that they need.

Warning signs of youth suicide include three distinct categories: 1) behavioral warning signs, 2) verbal warning signs, and 3) environmental factors (King, 2001). Table 2.1 highlights the primary warning signs within each category. In addition, it should be mentioned that with increases in modern technology today, some threats and warning signs can appear in e-mail messages and on Internet homepages and sites such as myspace.com. Many of the suicide warning signs are also signs for depression and usually will last for more than two weeks. However, some adolescents will act impulsively; therefore, early detection and intervention is critical to preventing youth suicide. By learning the warning signs and appropriately intervening when they are noticed, youth suicide can be decreased and lives can be saved.

Intervention Strategies

Identify Warning Signs and Appropriately Intervene

When an adolescent shows warning signs, adults must act quickly. Professionals and parents alike should seek to clarify their concerns by talking with peers and others close to the young person about whether they too have observed warning signs. In addition, the professional or parent should directly speak to the young person and voice their concerns of the warning signs they have observed. The young person should be directly asked if they are contemplating suicide, and if so whether they have a specific suicide plan, and access to carrying out that plan. If a young person affirmatively responds that they are suicidal or if the professional or parent still feels concern regarding the observed warning signs, then the young person should be immediately accompanied to a mental health professional for further assessment and help.

Develop and Follow a Suicide Intervention Plan

Professionals should follow the suicide intervention steps outlined at their agency or institution. These steps should seek to ensure the adolescent's safety and assess ongoing risk. If the adolescent verbally threatens to attempt suicide, the adult working with that youth should be completely focused on preventing the suicidal act (McKee, Jones, & Barbe, 1993). At that point, the adult should remain with the adolescent, ask direct questions for clarity, encourage the adolescent to talk and express feelings, actively listen, focus on the present, remain calm, ask the adolescent if he/she has a suicide plan, and alert the crisis intervention team (King, 2001). The adult should refrain from leaving the student alone, trying to be a hero, and promising to keep secrets of the threat. Table 2.2 provides a more specific listing of what to do and what not to do when an adolescent threatens suicide.

Each agency, facility, or institution that serves adolescents should have a crisis intervention team and a suicide intervention plan in place to follow in case of an emergency. This plan should include clear steps aimed at ensuring adolescent safety. When an adolescent threatens suicide, the adult working with the youth should

Table 2.1
Adolescent Suicidal Warning Signs

Behavioral Warning Signs

- Being depressed
- Showing changes in weight, appetite or behavior
- Showing changes in school performance
- Having loss of energy
- Losing interest in once-pleasurable activities
- Giving away cherished possessions
- Showing feelings of helplessness/hopelessness
- Abusing substances
- Withdrawing from others
- Alienating/isolating oneself
- Being preoccupied with death

Verbal Warning Signs

- "I am going to kill myself."
- "I want to die."
- "There is no reason for me to live anymore."
- "You all would be better off if I were dead."
- "I don't want to be a burden anymore."
- "I have had enough—I'm ending it all."
- "I can't stand living anymore."
- "Don't worry about me. I won't be around much longer."
- "I think suicide might be the answer."

Environmental Factors

- Previous suicide attempt
- Recent relationship breakup
- Death of a loved one
- Loss of job
- Academic problems
- Problems with the law
- Previous suicides in the family
- Recent disappointments
- Easy access to firearms
- Serious illness or belief that one is seriously ill
- Exposure to suicidal friends or family members

Practical Strategies for Preventing Adolescent Suicide

immediately remove the youth from contact with peers and should alert the crisis intervention team via the use of a prearranged signal or message (e.g., "Mr. Jones there is a message from the office"). The adult working with the youth should assess the suicidal risk by asking the youth if he/she has a suicide plan and if so, when the plan will take place and whether he/she has the lethal means to carry it out. This information should then be relayed to the crisis intervention team, the parents/ legal guardians and to a community mental health agency where a referral will be made. Parents should be apprised of the situation and informed of the immediate need for their child to be referred to a mental health agency. Parents will also need to be informed of the common referral and follow up steps taken to address this situation. After a referral has been made to a mental health agency, staff should follow up with the agency to determine the adolescent's ongoing status.

Encourage Youth to Become Proactive

Unfortunately, much stigma toward suicide and mental health treatment still exists today. More than one-half of high school students report that they would not feel comfortable talking to a school professional about a personal problem and only 1 in 3 would feel comfortable talking to a school counselor if they had problems (Armacost, 1990). Three in 4 adolescents would first turn to a friend for help if they were contemplating suicide (Gallup, 1991). Therefore, adolescents should know the warning signs of suicide and know what to do and where to go for help once these signs are noticed. Similar to adult intervention steps, when an adolescent recognizes the warning signs in a peer they should directly express their concerns with the peer. Available help resources should be stressed. The adolescent should also strongly encourage the suicidal peer to accompany them to a school counselor or other professional for help. If the peer refuses, the adolescent should immediately alert an adult.

Postvention Strategies

Prevent Against Copycat Suicides and Suicide Attempts

Following a suicide attempt or completion, adolescents are at an elevated risk for copycat suicides. One study found that following exposure to another individual's suicide, youth suicide increased 2 to 4 times more than among older age groups that are exposed to suicide (Gould et al., 1990). Therefore agencies and facilities should seek to implement postvention strategies to deter such behavior. Postvention steps should be in place well in advance

of the actual emergency as a means to most effectively deal with the individual(s) involved, those close to the youth, and the community (McKee, Jones, & Barbe, 1993). A clearly written plan can help prevent hysteria and confusion following a suicide. Specific postvention steps should include responding within 24 hours after the event by the crisis intervention team; educating staff about the situation; acting in a concerned and conservative manner; making a small-scale announcement to youth (for example, in individual classrooms) and avoiding large PA announcements; providing counseling sites at the agency, facility or institution; monitoring the ongoing climate of the agency; and avoiding any glorification of the suicide, for example, dedicating a tree (King, 1999). While some researchers have stated that certain memorial services such as a moment of silence, a yearbook photo, or a fund-raiser may help youth by drawing closure to the death, a point should clearly be made that there are more positive alternatives to solving problems and life stressors than engaging in suicidal behavior.

Conclusion

Adults who work with adolescents should ensure that their agency, facility or institution employs a comprehensive approach to youth suicide prevention. Such an approach should include prevention, intervention and postvention strategies. A specific crisis intervention plan should be developed and implemented that trains all staff regarding suicidal warning signs and the appropriate steps to take when warning signs are identified. Early detection and immediate intervention is key. In addition, staff should be trained on the appropriate intervention steps to take when an adolescent threatens or attempts suicide. Strategies aimed at increasing protective factors and positive connections among youth should also be sought. Remember, the goal is to get more youth positively connected to positive individuals and positive situations, thus saving lives in the process. ↪



Keith A. King

Keith A. King, Ph.D., C.H.E.S. is an Associate Professor of Health Promotion and Director of Research and Evaluation for the Center for Prevention Studies at the University of Cincinnati. His research and teaching emphases include suicide prevention, child and adolescent health promotion, survey development, and program evaluation.

Copyright © 2006, Integrated Research Services, Inc.

Table 2.2
Steps to Take When an Adolescent Threatens Suicide

DO	DO NOT
Remain with the adolescent	Leave the adolescent alone
Ask direct questions for clarity	Beat around the bush
Encourage adolescent to express feelings	Make promises you cannot keep
Focus on the present	Focus on the past or future
Actively listen	Promise to keep secrets of threat
Remain calm	Become flustered or anxious
Ask adolescent if he/she has a suicide plan and access to carrying out that plan	Try to convince the adolescent that things "aren't that bad"
Follow your intervention plan and alert the crisis intervention team	Try to handle the situation alone
Refer the adolescent to a mental health professional	Hope the situation will resolve itself without any mental health help

REFERENCES

- Armocost, R.L. (1990). High school student stress and the role of counselors. *School Counselor*, 38, 105–112.
- Blumenthal, S.J. (1990). An overview and synopsis of risk factors, assessment and treatment of suicidal patients over the life cycle. In S. Blumenthal & D. Kupfer (Eds.), *Suicide Over the Life Cycle: Risk Factors, Assessment, and Treatment of Suicidal Patients* (pp. 685–734). Washington, D.C.: American Psychiatric Press.
- Capuzzi, D., & Golden, L. (Eds.). (1988). *Preventing Adolescent Suicide*. Muncie, IN: Accelerated Development, Inc.
- Eaton, D.K., Kann, L., Kinchen, S.A., et al. (2006). Youth Risk Behavior Surveillance – United States, 2005. *Morbidity & Mortality Weekly Report*, 55(SS05), 1–108.
- Gallup, G. (1991). *The Gallup Survey on Teenage Suicide*. Princeton, NJ: George H. Gallup International Institute.
- Garrett Lee Smith Memorial Act (PL 108-355 – October 21, 2004). Available online [<http://jebfoundation.org/articles/GarrettLeeSmithS2634.pdf>].
- Gould, M.S., Wallenstein, S., Kleinman, M.H., O'Carroll, P., & Mercy, J. (1990). Suicide clusters: An examination of age-specific effects. *American Journal of Public Health*, 80(2), 211–212.
- Hicks, B.B. (1990). *Youth Suicide: A Comprehensive Manual for Prevention and Intervention*. Bloomington, IN: National Education Service.
- Hoyert, D.L., Kochanek, K.D., & Murphy, S.L. (1999). Deaths: Final data for 1999. *National Center for Health Statistics Monthly Vital Statistics Report*, 47(19), 1–108.
- Jobes, D.A., Casey, J.O., Berman, A.L., & Wright, D.G. (1991). Empirical criteria for the determination of suicide manner of death. *Journal of Forensic Sciences*, 36, 244–256.
- King, C.A. (1997). Suicidal behavior in adolescence. In R.W. Maris, M.M. Silverman, & S.S. Canetto (Eds.), *Review of Suicidology* (pp. 61–95). New York, NY: Guilford Press.
- King, K.A. (1999). High school suicide postvention: Recommendations for an effective program. *American Journal of Health Studies*, 15(4), 217–222.
- King, K.A. (2001). Developing a comprehensive school suicide prevention program. *Journal of School Health*, 71(4), 132–137.
- King, K.A., Price, J.H., Telljohann, S.K., & Wahl, J. (1999a). High school health teachers' perceived self-efficacy in identifying students at risk for suicide. *Journal of School Health*, 69(5), 202–207.
- King, K.A., Price, J.H., Telljohann, S.K., & Wahl, J. (1999b). How confident do high school counselors feel in recognizing students at risk for suicide? *American Journal of Health Behavior*, 23(6), 457–467.
- Kochanek, K.D., Murphy, S.L., Anderson, R.N., & Scott, C. (2004). Deaths: Final data for 2002. *National Vital Statistics Reports* 53(5). Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2005-1120.
- Leenaars, A.A., & Wenckstern, S. (1998). Principles of postvention: Applications to suicide and trauma in schools. *Death Studies*, 22(4), 357–391.
- McKee, P.W., Jones, R.W., & Barbe, R.H. (1993). *Suicide and the School: A Practical Guide to Suicide Prevention*. Horsham, PA: LRP Publications.
- McIntosh, J. (2002). *U.S.A. Suicide: 2002 Official Final Data*. Available online [<http://www.suicidology.org/associations/1045/files/2002FinalData.pdf>].
- National Center for Health Statistics. (1992). Advance report of final mortality statistics. *Monthly Vital Statistics Report*, 43(6). National Center for Health Statistics.
- Resnick, M.D., Bearman, P.S., Blum, R.W., et al. (1997). Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association*, 278, 823–832.
- Rosenberg, M.L., Davidson, L.E., Smith, J.C., Berman, A.L., Buzbee, H., Gantner, G., et al. (1988). Operational criteria for the determination of suicide. *Journal of Forensic Sciences*, 33, 1,445–1,456.
- U.S. Public Health Service. (1999). *Surgeon General's Call to Action to Prevent Suicide*. Washington, DC: U.S. Author.
- World Health Organization. (2000). *Preventing Suicide: A Resource for Teachers and Other School Staff*. Mental and Behavioral Disorders, Department of Mental Health, Geneva.