DOCUMENT RESUME

ED 301 813 CG 021 301

TITLE	Responding to Adolescent Suicide.
INSTITUTION	Phi Delta Kappa Educational Foundation, Bloomington, Ind.
REPORT NO	ISBN-0-87367-438-3
PUB DATE	88
NOTE	35p.; Prepared by the Phi Delta Kappa Task Force on Adolescent Suicide.
AVAILABLE FROM	Phi Delta Kappa, P.O. Box 789, Bloomington, IN 47402-0789 ($2.00).
PUB TYPE	Guides - General (050)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Adolescents; Elementary Secondary Education; Intervention; *Student Problems; *Suicide
IDENTIFIERS	*Adolescent Suicide; *Suicide Prevention

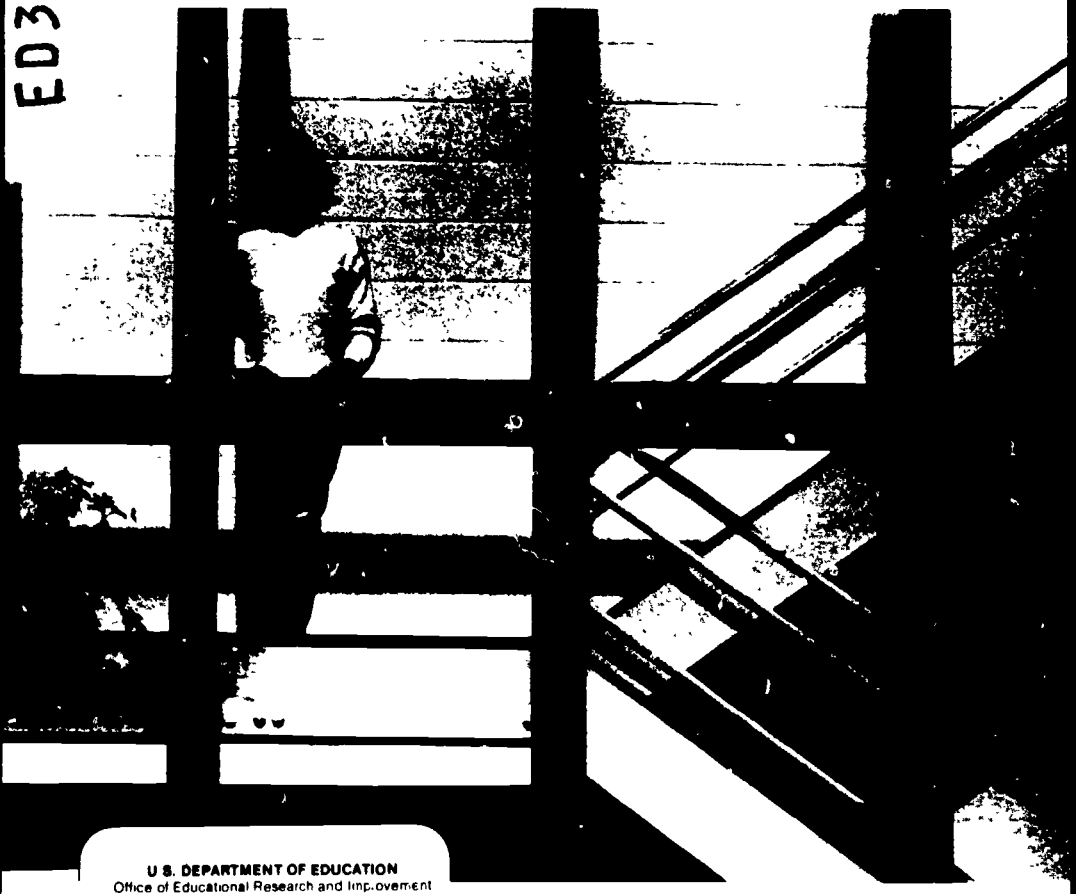
ABSTRACT

This publication is designed to help educators deal with the problems that arise after an adolescent's suicide. It recommends that teachers should be able to detect differences in students' responses to emotional problems. Following a preface and a brief review of the extent of the problem, the first chapter discusses which adolescents are vulnerable to suicide, noting that adolescent suicide is rarely precipitated by a single factor, but usually is a combination of factors. Risk factors described include depression; loss; moving; lack of attention from working parents; disappointments; substance abuse; chronic illness and handicaps; impulsivity; negative life events; and physical, sexual, and emotional abuse. The second chapter discusses dealing with the school situation after a suicide, describing the bereavement and recovery stages of denial, anger, acceptance, and resolution. A 10-step crisis management plan for suicide and how to put it into action is discussed in the third chapter. Establishing a school crisis team for dealing not only with suicides but also with other crises, such as accidents, drug overdoses, tornadoes, earthquakes, bomb threats, even riots, is discussed in the fourth chapter. Three levels of a school crisis team are presented: individual building, central office, and community support groups. Finally, community education in suicide prevention for two key audiences, parents and the media, is discussed. The appendix includes checklists for at-risk adolescents, symptoms of suicidal youth, and suicide threat. A bibliography is included. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED301813

RESPONDING TO ADOLESCENT SUICIDE



CG 021301

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

This document has been reproduced as received from the person or organization originating it.

Minor changes have been made to improve reproduction quality.

Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

D Kliewer

THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

by the Phi Delta Kappa Task Force on Adolescent Suicide

Barry D. Garfinkel, M.D.
Emeral Crosby
Myra R. Herbert
Abraham L. Matus
Jerilyn K. Pfiefer
Peter L. Sheras

RESPONDING TO ADOLESCENT SUICIDE

by the Phi Delta Kappa
Task Force on
Adolescent Suicide

Barry D. Garfinkel,
Chairperson

Emeral Crosby
Myra R. Herbert
Abraham L. Matus
Jerilyn K. Pfiefer
Peter L. Sheras

Phi Delta Kappa
Educational Foundation
Bloomington, Indiana

Cover design by Peg Caudell
Photography by Vladimir Bektesh

Library of Congress Catalog Card Number 88-61773
ISBN 0-87367-438-3
Copyright © 1988 by the Phi Delta Kappa Educational Foundation
Bloomington, Indiana

Table of Contents

Preface

In the spring of 1987, the Phi Delta Kappa Issues Board identified adolescent suicide as one of several critical problems in education needing attention The Issues Board convened a group of experts to develop a proposal to be presented to the Phi Delta Kappa Board of Directors for approval and funding. The proposal established a Task Force on Adolescent Suicide. This publication is one of the efforts of that task force, whose members are:

Barry D. Garfinkel, child and adolescent psychiatrist, head of the Division of Child and Adolescent Psychiatry, University of Minnesota Medical School, and chairperson of the task force.

Emeral Crosby, principal, Pershing High School, Detroit, Michigan.

Myra R. Herbert, chief . ocial worker, Fairfax County Public Schools, Fairfax, Virginia.

Abraham L. Matus, school psychologist, Ridgewood, New Jersey.

,erilyn K. Pfeifer, associate professor of education, Abilene Christian University (on leave) and supervisor of English and Language Arts, K-12, Abilene Independent School District, Abilene, Texas.

Peter L. Sheras, clinical psychologist and associate professor of education in the Curry Programs in Clinical and School Psychology, University of Virginia

Jack Frymier, senior fellow at Phi Delta Kappa, served as staff liais on for the Task Force.

This publication deals with the school's response to an adolescent suicide. The family of a young person who commits suicide is affected most directly, but hundreds of other people – students, teachers, administrators, and community members – may be affected, too. Educators can play an important role when a suicide occurs. This publication will help them to cope with the problems that arise after a suicide.

Extent of the Problem

Over the past 35 years there has been a steady and dramatic increase in the number of youth suicides. During this period the increase in suicides among young males has been 300%; among females, 230%. In the decade 1970 to 1980, the suicide rate among young males between the ages of 15 and 25 increased 50%. Suicide is now the second leading cause of death among high school students, exceeded only by motor vehicle fatalities.

Suicide was once considered a problem primarily of adults. Actually, the suicide rate is decreasing for all age groups except young people. This is both encouraging and disturbing. It is encouraging because the decrease in suicide rates for adults probably has occurred as a result of better recognition and treatment of conditions leading to suicidal behavior. It is disturbing because there has not been adequate recognition of early warning signs of suicidal behavior in adolescents and, therefore, a lack of effective preventive measures.

The problem of adolescent suicide takes on even greater magnitude when we examine the statistics of suicide attempts. It was formerly believed that for every completed suicide among young people, there were from 40 to 100 suicide attempts. It is now known that among high school students, there are almost 350 attempts for every completed suicide. One study reported that 3% of high school students attempt suicide each month.

Several factors relating to suicide attempts are important to our discussion. First, approximately 10% of suicide attempts will ultimately succeed. Attempted suicide is one of the best predictors for identifying those at greatest risk of committing suicide. Second, adolescent suicide attempts are

often "silent." Young people seldom call crisis hotlines, tell family or friends, or go to school guidance counselors. Although some may tell their friends, they tend to pledge those friends to secrecy. Students who inflict self-injury do not show up at hospital emergency rooms or police stations; they usually keep it secret. Only when the injury is severe is it recognized; but even then, it may be covered up by deception.

Suicidal behavior among young people increases in the fall and winter months; the highest rates of attempted and completed suicides occur between October and March. Many suicide attempts are associated with birthdays, holidays, anniversaries, and national events. Attempted and completed suicides also increase after stories about suicide appear in newspapers or on television, especially if the victim is a celebrity. This phenomenon has been described as "psychic contagion" and suggests that if the media describe a suicide in a sensational manner or give excessive attention to a particular suicide, already depressed students may decide to attempt suicide.

Because depression is the major predictor of suicidal behavior, students need to learn to recognize depression in themselves and in their peers. Adults in the school – teachers, counselors, coaches, administrators – need to know the symptoms of depression; they need to know what to look for; and they need to know how to work with young people in order to help them communicate their feelings more openly and to accept help from concerned adults

Educators have important roles to play, which only they can accomplish, in both prevention of suicide and in the aftermath of student suicide First, as professionals they are knowledgeable about the emotional and behavioral characteristics of students and understand the pressures of normal adolescent development. They are able to provide a consistent and mature perspective to the common emotional upheavals of adolescence

Second, because teachers spend many hours in direct contact with students, they can objectively compare students who are facing academic, family-related, or interpersonal problems. They should be able to detect differences in students' responses to emotional problems In the aftermath of a suicide, teachers are in a good position to observe behavior of students who are experiencing severe emotional reactions to the loss of a friend

Adolescent Suicide: Who Is Vulnerable?

Who are at risk of taking their own lives? If one asks this question of mental health professionals, the answer is: young people with psychiatric problems. If one reads the accounts of adolescent suicides in newspapers, one gets the impression that all teenagers are at risk, and suicide strikes for no apparent reason.

Neither of these perceptions is completely accurate. True, a person with a serious psychiatric problem is at much greater risk than the average person. But there are many young people who commit suicide without a specific psychiatric diagnosis. In fact, many *appear* to be "happy-go-lucky" and free of problems. Only hindsight shows that these young people were struggling with enormous problems, which they kept hidden.

Adolescent suicide rarely is precipitated by a single factor. When students who have attempted suicide are asked "Why?" they often respond: "It was a lot of things, some little and some big." In truth, the situations and events they recount are rarely "little." Most often it is a combination of factors escalating to the point where suicide seems the only route to escape.

Adolescence is an impulsive age, and suicide is often an impulsive act. Young people with a history of impulsivity appear to be at greater risk than others. Impulsivity, by itself, is not a cause of suicide; but in conjunction with other events, it may exacerbate self-destructive behaviors.

A history of depression makes one vulnerable to suicidal ideation. If a young person is depressed, either in reaction to a crisis or for reasons that are not apparent, he or she is at risk. When a person exhibits both depression and impulsivity, vulnerability increases.

Loss in any form puts young people at risk. For example, a child of parents going through divorce experiences a traumatic loss. Divorce usually means that there is only one adult in the family to offer support to a troubled child. Apart from the loss of a parent, there are other losses. Sometimes it is the loss of a familiar house, loss of friends, grandparents, and extended family, or loss of an expected standard of living.

The United States is the most transient nation in the world. It is not uncommon to meet students who have changed schools four or five times. Moving, in itself, is a stress factor for young people – difficult for young children and even more difficult for adolescents. During adolescence young people form tight social circles of peers. Moving means leaving a familiar peer group and trying to find a new circle of friends, which is often difficult. Moving means changing schools, with new teachers and unfamiliar routines. Bright and gregarious students usually handle this transition well, but slower or shy students may have difficulty making the adjustment and simply give up along the way. Thus, moving can be a disorienting and stressful event, which puts some young people at risk.

Today, two parents employed full time is the norm, and mothers may be as career-directed as fathers. Working parents can be loving and supportive of their children; but it requires considerable energy, which may not be there at the end of the work day. Adolescents are left with more free time and less supervision than in the past, but they still need the attention and mature outlook of parents.

Some adolescents are at risk when they face disappointments, such as poor grades, social rejection, or not making a sports team or cheerleading squad. Those who cannot cope with these disappointments become emotionally vulnerable.

Substance abuse does not cause suicide; rather, it is an indicator that trouble exists. For a depressed young person, the temporary "high" of drugs or alcohol provides a brief escape, only to be followed by a decline into depression. Use of alcohol or drugs can lower inhibitions and allow a young person to commit a self-destructive act. Overdosing may be a chosen method of committing suicide, but the problems are present before the use of drugs or alcohol. Habitual users, of course, are at serious risk regardless of whether or not they are considering suicide.

Young people with chronic illnesses and handicapping conditions also should be considered at risk. Many adolescents are obsessed with personal appearance; anything that sets them apart from their peers is a source of great concern. Temporary conditions affecting personal appearance such as acne or delayed physical development can create additional stress. Even

when illness or handicaps are not apparent, as with diabetes or hemophilia, young people tend to feel deformed in some sense and believe the world is staring at them.

Adolescents who have suffered physical, sexual, or emotional abuse are definitely at risk. Repeated acts of abuse destroy their sense of self-esteem and leave them with profound feelings of guilt.

The most vulnerable adolescent is one who is depressed, impulsive, and has experienced several negative life events. However, any young person attempting to cope with severe emotional problems, alone or in an ineffective way, needs assistance. Whenever teachers are aware of a situation where a young person is facing a series of traumatic events or a one-time crisis, they should be alert to the emotional fallout and offer whatever help they can.

Cluster Suicides

Adolescent suicides that occur in clusters in the same geographic area and over a short period of time are both puzzling and frightening. A romantic fascination with death is normal for adolescents, but currently there is no clear explanation for why the suicide of one teenager triggers others to do the same. What is known is that young people who take their lives in these situations do not always share the characteristics of the at-risk suicidal adolescent identified by research.

Although there is no satisfactory explanation as to why cluster suicides occur, one factor often associated with them is the accidental death of a student known in the community. There is also evidence that when the media report suicides in lurid detail (giving a full description of the methods used), the same methods have sometimes been replicated by the cluster suicide victims. The problem is complicated when reports by local media are picked up by national syndicates and networks. For example, in 1987 when four teenagers took their lives with carbon monoxide poisoning in New Jersey, similar incidents quickly followed in Illinois, Nebraska, and Virginia. No one knows how many attempts may have been made during the same time.

Several communities have formulated guidelines that may be helpful in curtailing cluster suicides, although it is not known how effective they are. Cluster suicides seem to end as mysteriously as they begin, and no one is certain which actions, if any, make a difference. But certain activities help to pull people together in a community and serve as a calming influence over what could be a panic situation. Following is a list of suggestions from communities that have dealt with cluster suicides:

1. Contact the local media and seek their cooperation in not reporting the deaths, except in the obituaries. If they consider this a restriction of

press freedom and do not agree, request that they make reports as brief and neutral as possible, and report the measures the school and the community are taking to cope with the event. Issue press releases to assist them.

2. Collect the names of the deceased students' peer group and see how many students are mutually acquainted.

3. Identify all students known to two or more of the deceased and consider them a high-risk group.

4. Create a protocol for a suicide/depression evaluation, or use a depression evaluation instrument, such as the Beck Depression Inventory. Nonmental health personnel can use standardized instruments. An established protocol ensures that all interviewers request the same information.

5. Obtain parent permission and assess all students in the high-risk group. In communities where there is a contingent of mental health professionals, seek their help. Many will volunteer if asked to assist in this kind of crisis. However, it is best to use licensed practitioners, and be sure they are covered by malpractice insurance.

6. After the evaluations are conducted and the high-risk group identified, determine what types of support are available to this group from families, friends, and agencies.

7. For those students at greatest risk, enlist at least four adults who are willing to serve as monitors – perhaps two at school and two in the community. Two or three times each week, each of these people should spend at least five or ten minutes with the student, in person or on the telephone, and ask specific questions in a direct manner. For example, the conversation might go as follows: How are you? Are you getting all your homework done? Are you seeing friends? Are you eating regularly? Do you have any sleeping problems? What are you going to do this weekend?

If a student appears to have trouble functioning, these adults should become the student's advocate and contact parents or teachers to explain what the difficulties seem to be. Advocacy should continue until the student seems stable and depression has lifted.

8. High-risk students might be asked to join discussion groups for six to eight weeks. These need not be "grief" groups, but rather a forum where all issues can be discussed – academic, social, or personal.

9. In addition to working with the media and students, it is imperative that regular information sessions be held for parents. Parents are likely to be anxious, and their anxiety can be projected in the form of blaming school officials. Such feelings can be dispelled by keeping open the channels of communication between school and home. It is reassuring to parents to know precisely what efforts the school is making to deal with the situation.

In the Wake of a Teenage Suicide

A teenage suicide is an overwhelming event in the life of a school, but school goes on. In fact, the organized routine of the school schedule provides a secure setting in which to work through the bereavement and recovery process and return to normal. Students must have a supportive environment in which to express their grief and work out their feelings. Teachers and other staff must be sources of sound information and helpful reassurance, even when they themselves feel a deep personal loss and sense of failure.

A suicide leaves in its wake many survivors, who must deal with a complex set of emotions. The death of a classmate from causes other than suicide may leave the survivor with feelings of abandonment, but with suicide the feeling is one of rejection. As one survivor put it: "He could not have loved me; he did not think I was worth living for."

Another common feeling among survivors is self-blame, sometimes called "survivor guilt." Parents and peers may blame themselves for not seeing the signs of the impending suicide or for not meeting the needs of the deceased. Survivors may question what they did to add to the deceased's stress or wonder why they did not foresee and stop the act.

Suicide also may leave survivors with feelings of rage over being abandoned. This feeling of abandonment, coupled with a sense of relief that the deceased person's problems will not plague him, can intensify survivor guilt. It is hard for survivors to reconcile these simultaneous feelings of anger and relief. Because they cannot understand them, they may try to deny them.

Finally, survivors of suicide may worry that they themselves might repeat the deceased's self-destructive act.

Following suicide, survivors frequently use denial to mask feelings. In a study of families in which an adolescent committed suicide, denial was manifested in the form of hostility toward the medical examiner and toward anyone who called the death a "suicide." Denial also may take the form of idealizing the deceased, making them larger than life.

Those closely identified with the suicide victim may perceive the act as an appropriate resolution to life's problems. The very fact that the taboo was broken by someone close may serve as a stamp of approval for the act and even suggest to survivors that when they are overwhelmed by problems, they, too, might be vulnerable to suicide.

Social stigma surrounding suicide can compound the problems of survivors. Those who usually would provide support may find they are unable to comfort the survivor of a suicide. This failure of the informal support system leaves many survivors to deal with their complex feelings isolated and alone. When this happens, the decision of some survivors to deny the fact of a suicide is understandable.

Bereavement and Recovery

The bereavement and recovery process includes four stages: denial, anger, acceptance, and resolution. By becoming familiar with the characteristics of these stages, educators can help themselves and their students to understand their feelings when a student commits suicide. Each of these stages is discussed below.

Denial: On first hearing of a student suicide, the common response is denial. "It can't be true. He was cleaning the gun, and it just went off." Questions and contradictions quickly follow. "It must have been an accident. She wouldn't really do that." "Why did it happen? He couldn't have been serious." "Is there some chance that he is still alive, that the shot wasn't fatal?"

Even through the funeral and burial ceremony, denial continues. Students are in shock. They go through the motions of attending the funeral or memorial service without internalizing what has happened. For many this may be their first confrontation with the reality of death; it may be their first funeral. Their faces are often blank, expressionless. They look to others for behavior to model. They seek answers to questions they do not even know how to ask.

After the burial ceremonies, denial continues. The victim is gone but exists somewhere else. Denial allows one to assume that the deceased has

moved away, taken a vacation, but will return. Some survivors convince themselves that they can continue their relationship with the victim and, at times, actually engage in conversation with the deceased.

Denial takes many forms. Some students will avoid the funeral; some will be fearful of speaking to the suicide victim's parents; some may want to drop out of school and never return. The length of the denial stage will vary. For some it is only a matter of a few hours or a day; for others it may linger on for weeks or months.

Some students will not talk about suicide, ever. While they may never verbalize their feelings, they eventually will respond and accept the reality of death. Although many forms of denial appear irrational, students must be allowed to work through this stage at their own pace.

Teachers also go through the denial stage when a student they know commits suicide. They may be preoccupied with how they will handle the situation when it come up in class the next day and mask their own intense feelings about the suicide victim. Educators need an outlet to express their feelings – perhaps in a group of their own or at a special faculty meeting. They, too, need to grieve, and doing so prepares them to deal with student grief.

Anger: At the same time that adolescents are feeling shock, loss, fear, and guilt, they also are full of anger. They want to lash out at someone. They cannot lash out at the victim. The victim is gone. Sometimes their anger is directed at themselves, because they feel they are accomplices to the suicide by what they did did not do. Their anger should be directed not at the victim and not at themselves, but at the act of suicide.

Anger prompts action. One can become angry at cancer and respond by contributing to research to find a cure for it or by altering one's lifestyle to avoid contracting it. One can become angry at deaths caused by automobile accidents and respond by lobbying for seatbelt laws and safe speed limits. One can petition city hall for traffic signals to make intersections safer. So, too, can the anger generated by the suicide of a friend or classmate be harnessed and directed at affirming life.

In the bereavement period following a student suicide, one should recognize that anger occurs. Educators should acknowledge this anger in themselves and in their students but then go on to direct that anger into positive actions leading to recovery.

Acceptance: Acceptance of a suicide may come in a week or a month, or even a year, but it comes eventually. The victim is gone and will not return. The finality of death is accepted. This is a difficult time for adolescent survivors, but acceptance is a critical step in their recovery.

Educators need to help students recognize a suicide for what it is – a tragic death. Students will come to accept the death and even the circumstances surrounding it, but they cannot be allowed to accept the idea that suicide is justified. Students also must learn that they can exercise control over their own lives. even in the face of adversity.

Resolution: This stage in the bereavement process is one of accepting the reality of death and moving on with life. It is the recognition that what has occurred cannot be changed. It does not mean that the dead are forgotten or any less valued as friends or family members. Moments of sorrow may linger, but they are no longer obstacles to productive living. Fortunately, adolescents' lives are so full of new experiences and activities that arriving at the resolution stage may occur sooner than it does with adults.

In the aftermath of a student suicide, educators must be in touch with their own feelings if they are to help their students and parents to cope with the traumatic event. The items below serve as a summary of the bereavement process and of the actions educators can take to help them through the process.

1. You may feel overwhelmed by the intensity of what you are feeling. Know that such intense feelings are normal and common.
2. You may feel angry at the person who committed suicide or at someone close to that person. You may be angry at the world in general. Such anger is common.
3. You may feel guilty for what you think you did or did not do. You are not to blame.
4. You may feel hopeless and depressed. These feelings are common and in time will pass.
5. Remember, you are a person of worth, even though you may not think so at the time.
6. Express your feelings to others. Denying or hiding your feelings may lead to depression. If necessary, express your feelings through creative activity.
7. Learn about the grief process so you know what to expect and can explain it to others.
8. Call on your personal faith to help you through the trauma.
9. Be part of a support system that includes colleagues and others outside of school. The trauma of a student suicide does not go away at the end of the school day.
10. Do not be afraid to use professional help as part of your support system.

Managing the Crisis of a Suicide

Coping with a student suicide begins with a crisis management plan. Such a plan should include a statement of purpose, an explanation of what the procedures will be for students and families, and the reasons why the procedures are needed. Because the plan will involve policy questions, it should have the support and approval of the school board. Implementing the crisis management plan should include information and awareness sessions for teachers, administrators, guidance counselors, social workers, psychologists, and nurses.

Crisis management means having a plan before a crisis occurs. Following is a list of decisions and activities involved in setting up a crisis management plan:

1. Decide who is to be in charge during a crisis. Designate a substitute in the event that the appointed person is unavailable at the time of the emergency. Make certain that all staff know who that person is.

2. Hold an inservice meeting on suicide in every high school and intermediate school at least every other year. Such inservice meetings should include a summary of the extent of adolescent suicide nationally, descriptions of behavior associated with suicidal tendencies, specific information about what to do if suicidal behavior is exhibited, and community agencies and other support services to which students can be referred.

3. Hold an inservice meeting for school secretaries on how to handle telephone calls from parents, other community members, and the media when a suicide is reported. Secretaries need such training since they are usually the ones to answer the phone when a crisis arises. Have a contingency plan for additional secretarial help if the situation requires it.

4. Set up "phone trees" so that critical information can be communicated as quickly as possible to those who need to know it. The complexity of the phone tree will depend on the size of the community and its school system.

5. Have a plan for making space available for community meetings. The plan should include alternative sites in the community if space is not available in a school.

6. Establish a police liaison. Designate one person from the school system to communicate with the police. Inform the police that this person can be telephoned night or day to report a suicide and other relevant information that can be released. This person, in turn, should contact key people in the schools. Information supplied by the police usually is kept confidential, but having accurate information allows school personnel to quell any rumors that frequently arise when a suicide occurs.

7. Establish a working relationship with community health agencies and other resource groups that can provide support if a suicide occurs.

8. Hold a practice "crisis alert" session, perhaps on a teacher professional day, to prepare the staff for what they would do in a real crisis. Through role playing, the staff can become aware of the problems that might arise and then discuss how they will respond.

A Suicide Crisis Plan in Action

When a student suicide occurs, the crisis management plan is put into action. The staff know what to do and are prepared for any contingencies. For example, if a student suicide occurs over the summer vacation, the circumstances will be different than if it occurs over a weekend during the school year. In one large high school of nearly 5,000 students, which did not have a crisis plan, a popular 10th-grade student committed suicide on a Wednesday. The staff began organizing to deal with it on Thursday. On Friday the area was hit by a hurricane and school was closed. Monday came, and the school officials assumed that, because things were quiet, the crisis was behind them. But on Wednesday a second student, the closest friend of the first suicide victim, took his life. The student body erupted with expressions of anger and outrage, which the school officials were unable to contain. With a crisis plan in place, much of the turmoil in this high school might have been avoided.

Following are the steps of a crisis management plan that a school should put into action when a student suicide occurs. Although the circumstances will vary in different communities, each step should be addressed by those in authority.

Step 1. Verify that the suicide occurred. Contact the police, hospital authorities, or coroner to be certain that a death has occurred; and get the exact name of the student involved. Do not accept a statement from students or teachers that a student has died or that a death was by suicide without verifying that statement.

Step 2. Notify the key people in the school system (the School Crisis Team) once a reported suicide is verified. Follow the crisis management plan that has been developed. Call student personnel staff together and release them from other responsibilities in order to assist in the emergency. Appoint a spokesperson to deal with the media if such a person has not previously been designated. Draft a press release and disseminate the same information to all media representatives. Ask reporters not to interview students or teachers on school property. (Note: Media representatives might object on First Amendment grounds that you are restricting access to information. If the press does request a statement, restrict the comments to the suicide victim's school activities, not personal information about the student or family.)

Step 3. Take action immediately. Delay feeds rumors, which only compound the situation. Delays also engender anger from students, who feel that information is being withheld from them.

Step 4. Prepare a general statement for the student body to be made by the principal or designee. Do not mention details of the suicide. A straightforward announcement of the death of a student and a simple statement of sympathy and condolences to the family is all that is necessary at this time. A statement that more information will be forthcoming, when it is verified, can be reassuring to the students. Students also appreciate being told about funeral or memorial service arrangements. If that information is not available at the time of the announcement, state that it will be provided when available.

The general announcement can be made on the public address system. Calling an assembly to announce the death to the entire student body is not recommended. Questions will arise that cannot be answered, and emotions may get out of control in the large assembly setting.

Some schools write out the announcement of the death and deliver a copy to each classroom during the same period for the teacher to read to the students. This method is more personal and is effective as long as all students receive the announcement at the same time. It can be highly disruptive if some students have the information and some do not when they flood into the halls at the end of the period.

If students ask direct questions, be as truthful as possible but exercise discretion. And do not hesitate to say, "I don't know." Do not reveal such details as the cause of death, time of death, circumstances under which the death occurred, or contents of any suicide note left by the deceased. Such details all are subject to misinterpretation, and all the facts may not be known until an official report is released. Because suicides sometimes are recorded as accidental deaths and because some families will go to great lengths to cover up a suicide, teachers should restrict their answers to students' questions to basic information and avoid speculation.

Step 5. Hold a faculty meeting as soon as possible. If it is scheduled for the end of the day, send a notice of the meeting early in the day. Alert the student personnel staff and enlist their help in providing general support to the teaching staff.

Step. 6. Set up small-group meetings for students who were close to the suicide victim to discuss their feelings. Allow other students to join a group, even if they were not close to the victim. Groups should be no larger than 15 to 20 students. Larger groups tend to be dominated by the more verbal students; those with the greatest need to share their feelings may never have an opportunity to do so. If possible, the groups should have privacy. Avoid putting all the groups in a large gymnasium, where if one group becomes particularly emotional, it will be disruptive to the other groups.

Counselors should be on hand to spend time with students who wish to talk individually. However, most adolescents will feel more comfortable discussing their feelings in a group with their peers. Be alert for students who were close to the victim who do not join a group; also, those students who have recently lost a friend or family member. This latter group may not be readily identified if they were not close to the victim. But other students can help identify them if you ask: "Are there other students who should be with us now?"

The dynamics of these small groups deserve some comment. Sometimes students wander from group to group or form subgroups without an adult leader. Insist that students stay with their group for at least one class period. Sometimes tensions arise in a group because one or more members of the group was not a close friend of the victim and "could not possibly feel what we feel." When such tension surfaces, deal with it immediately. Explain that anyone can experience feelings of loss and that no one's grief is to be discounted as less important or less real. Needless to say, such groups often help the school staff identify other students who need special attention. On some occasions students will ask to meet by themselves, but experience has shown that students often cannot handle the intense emotions

generated. Student groups are best conducted with one or two adult leaders present. Knowing that there are adults who care is reassuring to students.

Some schools with established peer counseling programs have experimented with using peer counselors as group leaders. This is not recommended. Peer counselors are students and are as likely to be deeply affected by a suicide as other students. Further, they rarely have either the objectivity or the interpersonal skills to handle emotionally charged issues. However, because of their peer counseling training, they function well as group members. They have spent many hours in groups and know how to participate. They are not apprehensive about discussing their own feelings. They can be effective catalysts in helping other students to work through their feelings.

When a suicide occurs, some schools have allowed students to leave school with parental permission, but sometimes students will defy authority and leave school without permission and gather with close friends in someone's home. If school personnel are aware of such meetings, they should make an effort to establish that there is a parent or other responsible adult in the home.

Step 7. Arrange for back-up help from community agencies when an emergency occurs. For example, school personnel alone cannot deal with the fallout of a cluster suicide. It demands the cooperation and support of the entire community. By establishing a liaison with the staffs of community agencies and providing them with information about the school's crisis management plan, they will be prepared to lend assistance when a crisis occurs.

Step 8. Ask school staff to make themselves available to parents and other members of the community. An evening meeting to discuss the issues surrounding adolescent suicide and to hear what the school is doing to meet the crisis can be reassuring to parents. Parents also appreciate receiving guidance about what to do at home. Remind parents that after a student suicide is reported, they should know the whereabouts of their teenagers at all times, and that they should not leave troubled young people alone, particularly over a weekend.

Step 9. Give students direction as to what is appropriate as a memorial to a student who has committed suicide. There is a fine line between dramatizing a death and doing something that allows students to express a sense of loss and to channel feelings. A small gesture such as planting a tree or writing a poem can commemorate feelings of loss.

Sometimes students will come up with activities that are inappropriate and will become quite angry if they are refused permission to carry them

out. In one school students wanted to organize a rock concert as a memorial. In another, where the suicide victim was a well-liked member of the band, the band members wanted to dedicate a concert to him. In such cases it is important to continue the dialogue. By keeping the discussion open, the fervor tends to ebb and something mutually acceptable usually can be agreed on. Do not fly the school flag at half staff. Do not have a moment of silence in an all-school assembly. Do not have a memorial service at the school. Do not have an "In Memoriam" page in the school yearbook. In short, do nothing to glorify the death.

Step 10. When advising students who wish to attend funeral services or to take part in them by writing something to be read at the service, the wishes of the family are paramount. Some families will welcome such participation, but others will refuse requests and ask that students not attend. The student groups discussed in Step 6 can be a place where students can talk through their feelings about attending or not attending the funeral.

Follow-Up Activities

After the immediate crisis of the suicide is over and the 10 steps discussed above have been addressed, there is a need for follow-up activities for both students and faculty. The discussions in the student groups may have identified students who were not known to be at risk. Discussion in groups often will touch on the deaths of parents and grandparents, the loneliness of moving, the loss of friends, even the deaths of beloved pets. In some students, latent fears and suicidal ideation will surface. Faculty, too, can become deeply depressed after a student suicide, particularly those who have had a direct association with the victim in the classroom or in extracurricular activities. Personal grief may resurface. It may be necessary to continue group meetings for bereaved students and staff beyond those initially held at the time of crisis.

Opinions differ as to what are the most appropriate types of follow-up activities after a student suicide. However, most authorities agree that isolated discussions of suicide with students should be avoided. A better approach is to address the broader context of social and emotional issues affecting adolescents. Students can explore the strains and pressures they feel and share their coping mechanisms as well. In such a context, suicide is not singled out as a dramatic entity but, rather, is seen as a bad choice in the field of options.

Some schools have used the panel discussion format in which a group of students deal with issues they feel are most stressful to teenagers and use their personal experiences as the basis for the discussions. Students

selected to participate on the panel should be articulate and willing to discuss such issues as academic pressure, social pressure, divorce, combined families, moving and readjusting to a new school, learning disabilities, family death, competition, cultural differences, and being a minority. The students on the panel also share their coping mechanisms for these issues. The panel discussion format can be effective for both student and parent audiences.

Another follow-up activity some schools have used is a Student Stress Program. This is a small-group activity and participation is voluntary. The group is led by a staff member skilled in group techniques and knowledgeable about adolescent issues. A guidance counselor, school social worker, or school psychologist usually has these qualifications. The group meets weekly for about six weeks with an established starting and stopping time. No outside observers are allowed. The participating students agree to attend each session and to observe strict confidentiality.

The Student Stress Program provides a structure in which the group members can draw support from one another. Because many students will have several areas of stress in their lives, the group interaction gives them an opportunity to sort out the pressures, put them in perspective, and share effectiv. ways of coping with them. In addition, the group can focus on stress issues in their particular school and perhaps come up with suggestions for lessening them.

Establishing a School Crisis Team

A school crisis team can be a highly effective organizational unit for dealing not only with student suicides but also with other crises, such as accidents, drug overdoses, tornadoes, earthquakes, bomb threats, even riots. Crisis teams in a school system can operate at three levels: individual building, central office, and community support groups. Well-functioning teams at each level provide a network that can take action whenever a crisis arises.

Building Level Crisis Team: The building level team usually is led by the principal, with an alternate leader designated in the principal's absence. In addition to teachers, the team might include a coach, guidance counselor, school nurse, school secretary, and custodian. The team would have responsibility for the following:

1. Establishing a protocol for dealing with crisis.
2. Planning and implementing an inservice program for faculty and staff about student suicide and procedures for dealing with a suicide.
3. Cataloguing community resources to help with crises and establishing a liaison with them.
4. Preparing a report for the central administration at the outset of a crisis and following the crisis.
5. Providing organizational assistance during a crisis, including assessing the need for additional resources outside of school.
6. Identifying and monitoring students at risk.
7. Debriefing personnel after the crisis and providing follow-up activities.

Central Office Crisis Network: In addition to crisis teams at each school building, the crisis network should include a team at the central office level. This team might include the superintendent or someone designated by the superintendent, a representative of each of the school crisis teams, and other central office personnel, such as the director of pupil personnel services and director of school social workers. It also might include consultants outside the school system. The central office crisis network would have responsibility for the following:

1. Overseeing and coordinating the building level teams.
2. Authorizing resources for areas where they are most needed; for example, providing more counselors to a school whose staff may be overburdened in dealing with a crisis.
3. Collecting and disseminating educational materials to schools for training crisis team members and faculty.
4. Establishing a central library of materials on suicide for faculty, staff, and students.
5. Conducting a mock crisis event to test the crisis management procedures.
6. Evaluating responses to crises with a report to the superintendent and a plan for follow-up.
7. Establishing a community support team and encouraging input and support from its members.

Community Support Group: This component of the crisis network includes representatives from community and government agencies. Members of this team might include mental health center personnel, physicians, nurses, lawyers, judges, probation officers, media personnel, and clergy. These persons not only bring their own professional perspective for dealing with a suicide crisis, they also can provide access to the resources of the community and government agencies with which they are associated. Listed below are some of the agencies that can be called on to help troubled young persons and their families in times of crisis.

Emergency services: police, ambulance, first-aid squads, fire department, hospital emergency rooms, hot lines (suicide, drug abuse, runaways, child abuse), Alcoholics Anonymous, battered women programs, and juvenile justice programs.

Community out-patient services: mental health centers, hospital outpatient services for adolescents, drug and substance abuse programs, family service agencies, crisis intervention programs, pregnancy counseling services, venereal disease information and treatment, and youth-serving agencies such as Y's and community centers.

Community in-patient services: general hospital adolescent units, psychiatric hospital adolescent units, halfway houses for adolescents, and group homes for juveniles.

Other resources: national volunteer associations, local board of health, funeral directors, religious groups, Society of Compassionate Friends, local chapters of Suicide Prevention Centers, various university-based counseling programs, and local support groups for survivors of suicide.

Small communities will not have all of the resources listed above. Schools in smaller communities might link up with neighboring communities where specific resources may be available and establish reciprocal arrangements for use of resources. Schools also should maintain periodic contact with community agency representatives and invite them to participate in a meeting with the school crisis team.

Educators also can help students to become aware of community resources that are available in times of crisis. For example, high school students in sociology and psychology courses might be assigned to investigate and compile a list of community agencies that offer services to youth in need of counseling. The list could be printed in the school newspaper or printed in a small brochure. Some schools have produced a wallet-size laminated card on which is printed the name and phone number of helping agencies in the community.

Community Education and Suicide Prevention

Adolescent suicide is a problem for the entire community, not just the schools. But schools can play an important role in educating the community about the problem and about steps that can be taken to prevent or lessen the problem. Two key audiences for community education are parents and the media.

Parents

Teachers and administrators who work with adolescents can provide parents with a better understanding of the teenage culture and the pressures young people face today. One way educators and community mental health specialists make parents aware of these pressures is by sponsoring a series of meetings devoted to student mental health issues. Relevant topics for these meetings might include drugs, alcohol, sex, academic pressure to get into college, and communicating with adolescents.

In addition to general parent education programs on adolescent problems and pressures, there is need for more specific parent education when a student suicide occurs. Parents are shocked and frightened. Some will come to a meeting who have never before attended a parents' meeting Many are not prepared to discuss suicide and become quite anxious about what to say. Typical questions asked are: "How much should we talk about this at home?" "What should I say to my teenager?" "How do I know if my son or daughter is at risk?" "Should I let my son go to the funeral?" Parents often begin to scrutinize their teenagers as they never have before. A smattering of "pop psychology" from magazines or television programs may be

the only information about adolescent suicide many parents have. They need reliable information and reassurance.

Parents need to understand that rarely is a single factor enough to place a child at risk. All children of divorced parents or all children under academic pressure are not necessarily suicidal. However, some symptoms and behaviors must be taken more seriously than others. For example, symptoms of clinical depression should receive immediate attention. By helping parents assess a cluster of factors, they will know whether there is reason for concern or a need for professional consultation.

Parents need to understand that they should express their own fears and insecurities when a student suicide occurs. Sharing concerns about death and the feelings of loss are not just the province of young people; they are the experience of all people. Parents should be urged to to speak openly and honestly, to voice their concern, and to express their grief. Parents must share their own feelings and allow children to feel comfortable sharing theirs.

In the aftermath of a student death, schools can forge bonds with parents that will continue to be a basis for mutual trust and communication essential for continued community support.

Media

The business of the media is to inform the public. But when a student suicide occurs, sensational coverage often follows, which is detrimental to the good of the community. There is evidence to suggest that detailed descriptions in the media of the methods used to commit suicide will encourage vulnerable adolescents to use those methods to take their own lives. If school officials present a solid rationale for why sensational reporting of adolescent suicides is harmful to the community's young people, the media usually will respond in a responsible manner.

In one community, school personnel and mental health professionals expressed their concerns to the executive editor of a large national newspaper and were invited to give a seminar for all local reporters and editors of the paper. As a result, subsequent coverage of student suicides and traumatic events affecting children has been handled with restraint and sensitivity. In addition, school personnel, working with a concerned TV reporter, organized a program for the local chapter of Sigma Delta Chi, the professional journalism society, which was attended by representatives from all the newspapers and TV stations in the area. The discussion was frank and lively and pointed out the different perspectives to the problem, but the result was greater sensitivity in reporting student suicides.

One of the media's ongoing concerns is "scooping" the competition when a story breaks. This can be controlled to some extent if a ground rule is established that all media get exactly the same information at the same time. Each school should appoint a media spokesperson who gives the same information to all reporters. This person might be assigned to prepare a press release for simultaneous release to all media. The information released should first be verified by the police or the family. The school should have a strict policy of releasing information about only the deceased student's school activities. Personal information should come only from the student's family.

If school officials take these simple steps in educating the community, they will help to protect and support adolescents and their families in the aftermath of a student suicide.

Appendix

The checklists in this Appendix serve as a summary of many of the points made in this publication. **They may be reproduced for educational purposes without the permission of the publisher as long as the source is cited.**

At-Risk Adolescent Checklist

Listed below are several factors associated with at-risk adolescents. None of these factors alone is an indication of suicidal tendencies; but educators should be alert to clusters of these factors, which could indicate potential problems.

1. Inability to compete in school, failing grades.
2. Family instability (divorce, blended family, neglect, and abuse).
3. Death or chronic illness of a loved one or pet, or the anniversary of such an event.
4. Failure to communicate feelings of unhappiness.
5. Health problems.
6. Major disappointment or humiliation (real or imagined).
7. Economic insecurity.
8. Parental role failure.
9. Desire for revenge against a girl friend, boy friend, or significant other.
10. Sense of not belonging to anyone (family, community, school).
11. Family history of suicide or suicide attempts.

Symptoms of Suicidal Youth Checklist

1. Extreme mood swings (violent or rebellious behavior, sudden cheerfulness).
2. Difficulty concentrating.
3. Sudden lifestyle changes.
4. Withdrawal or isolation from peers, family, or school activities.
5. Neglect of personal appearance.
6. Previous suicide attempts.
7. Loss of friends (boy friend, girl friend, best friend).
8. Giving away possessions, pulling affairs together, voluntarily cleaning room, or throwing things out.
9. Decline in school work, failing grades, cheating.
10. Noticeable change in sleeping habits and energy level.
11. Frequent suicidal talk (revealed through writing, drawings, or indirect verbal expresssion).
12. Drug use (half of suicidal youngsters are involved in substance abuse).
13. Many unexplained absences.

Suicide Threat Checklist

Do these things:

1. Remain calm. Stay with the student. Remember, the student is overwhelmed, confused, as well as ambivalent.
2. Get vital information if possible (name, address, home phone number, parent's work number). Send another teacher or student to get help.
3. Clear other students from the scene. Direct them to return to class.
4. Assure the student that he or she has done the right thing by talking to you. Try to win the student's trust. Assure the student that emergency help is coming. Tell the student that there are options available.
5. Get the student to talk. Listen! Listen! Listen! Repeat back what you hear the student saying (help the student define the problem). Acknowledge the student's feelings ("You are really angry." "You must feel humiliated.")
6. Establish direct eye contact with the student. Speak in a calm, low voice. If student is about to commit suicide, buy time. Say, "Don't jump. Stand there. Talk with me. I'll listen." Show that you are not shocked by discussing suicide.
7. Try to get the student to agree to a verbal "no suicide" contract ("No matter what happens, I will not kill myself.").

8. Monitor the student's behavior constantly.
9. Make a mental note at the time of the incident of what the student says.
10. Ask the principal or another administrator to contact the parents with the message that their child is hurt and that they will be called back immediately with the name of the hospital where they can join their child. Tell them to keep their telephone line clear.

Do Not Do These Things:

1. Do not ignore your intuitions if suicide is suspected.
2. Do not minimize the student's threat. Take it seriously.
3. Do not be concerned about long periods of silence. Give the student time to think.
4. Do not leave the student. Do not let him or her go to the restroom.
5. Do not lose patience with the student.
6. Do not argue with the student about whether suicide is right or wrong.
7. Do not promise confidentiality. Instead promise help and promise privacy.
8. Do not discuss the incident in the teachers' lounge or with another student.

Bibliography

Barraclough, B.; Shepherd, D.; and Jennings, C "Do Newspaper Reports of Coroners' Inquests Incite People to Commit Suicide?" *British Journal of Psychiatry* 131 (1977): 528-32.

Cohen-Sandler, R.; Berman, A.L.; and King, R.A. "Life Stress and Symptomatology: Determinates of Suicidal Behavior in Children." *Journal of the American Academy of Child Psychiatry* 21 (1982): 178-87.

Crow, Gary A., and Crow, Letha. *Crisis Intervention and Suicide Prevention: Working with Children and Adolescents*. Springfield, Ill.. Charles Thomas, 1987.

Davidson, L., and Gould, M.S *Contagion as a Risk Factor for Youth Suicide*. Washington, D.C : Department of Health and Human Services, 30 April 1986.

Elkind, David. *All Grown Up and No Place to Go: Teenagers in Crisis* Reading, Mass.: Addison-Wesley, 1984.

Garfinkel, B.D ; Froese, A., and Hood, J. "Suicide Attempts in Children and Adolescents." *American Journal of Psychiatry* 139 (1982) 1257-61.

Giffin, Mary, and Felsenthal, Carol. *A Cry for Help* Garden City, N.Y : Doubleday, 1983

Giovacchini, Peter. *The Urge to Die*. New York. Macmillan, 1981

Golombek, H , and Garfinkel, B.D. *The Adolescent and Mood Disturbance*. New York: International University Press, 1983.

Gould, M.S., and Shaffer, D "The Impact of Suicide in Television Movies." *New England Journal of Medicine* 315 (1986): 690-94

Hawton, Keith. *Suicide and Attempted Suicide Among Children and Adolescents*. Beverly Hills, Calif.: Sage, 1986.

Johnson, S.W., and Maile, M.J. *Suicide and the Schools. A Handbook for Prevention, Intervention, and Rehabilitation*. Springfield, Ill.: Charles Thomas, 1987.

Kazdin, A.E. "Assessment Techniques for Childhood Depression: A Critical Appraisal." *Journal of the American Academy of Child Psychiatry* 20 (1981): 358-75.

Kierman, Gerald L. *Suicide and Affective Disorders Among Adolescents*. Washington, D.C.: American Psychiatric Press, 1985.

Klee, S.H., and Garfinkel, B.D. "Identification of Depression in Children and Adolescents: The Role of the DST." *Journal of the American Academy of Child Psychiatry* 4 (1984): 410-15.

National Institute of Mental Health. *Adolescence and Depression*. Rockville, Md : U.S. Department of Health and Human Services, 1984. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.(DHHS Pub. ADM8 4-1337)

National Institute on Drug Abuse. *Adolescent Peer Pressure: Theory, Correlates, and Program Implications*. Rockville, Md.: U.S. Department of Health and Human Services, 1981.

Pfeffer, Cynthia R. *The Suicidal Child*. New York: Guilford, 1984.

Phillips, D.P., and Chartensen, L.L. "Clustering of Teenage Suicides After Television News Stories About Suicide." *The New England Journal of Medicine* 315 (1986): 685-89.

Salladay, S.A., and Royal, M.A. "Children and Death: Guidelines for Grief Work." *Child Psychiatry and Human Development* 11, no.4 (1981): 203-12.

Slaby, A.E. "Prevention, Early Identification and Management of Adolescent Suicidal Potential." *Rhode Island Medical Journal* 69 (1986): 463-70.

Slaby, A.E., and Kramer, P. "Evaluating and Managing Self-Destructive Potential Behavior." *Psychiatric Hospital* 16, no. 1 (1985): 330-39.

Smith, K., and Crawford, S. "Suicidal Behavior Among 'Normal' High School Students." *Suicide and Life-Threatening Behavior* 16 (1986): 313-25.

Phi Delta Kappa
P.O. Box 789
Bloomington, IN 47402-0789

ERIC Full Text Provided by ERIC