**Frequently Asked Questions About Suicide**

**Developed in conjunction with the American Association of Suicidology (www.suicidology.org)**

1. What are the warning signs of suicide?

By far the majority of suicidal young people give warning signs of their despair. Some estimate, as many as 80% of those thinking about suicide let others know of their intent because they are ambivalent and want others to be aware of their emotional pain and stop them from dying. A warning sign does not automatically mean a person is going to attempt suicide but it should be taken seriously.

# Verbal Clues

Direct statement about suicide such as “I want to die.” Or, “I am going to kill myself.”

Indirect or subtle statements indicating a wish to die, of hopelessness and helplessness, or that all problems will soon be solved. Examples are: “I want to go to sleep and never wake up.” “I should never have been born.” “Soon I won’t have to deal with this anymore.” “You would be better off without me.”

# Behavior Clues and Behavior Changes

Indicators of depression:

 Sadness and crying

 Withdrawal from social contacts, isolation

 Disinterest in previous activities, hobbies, sports, or school

 Inability to complete assignments, drop in grades,

Lack of energy

Change of sleep or eating patterns

Neglect of personal hygiene and personal appearance

Giving away prized possessions, making final arrangements

Unusual mood shifts

Impatience or impulsivity

Prior suicide attempts

Increase use of drugs or alcohol

Taking risks, frequent accidents

Saying “good-bye”

Reoccurring death themes in written or artistic expressions

Disorientation, disorganization, confusion

Grief over loss of a significant relationship, including break-ups with boyfriends and girlfriends.

Distress over school failure

Poor communication or relationship with parents

Plan or attempts to secure the means

2. Who is at risk?

The risk for an attempt is high (about 1 in 10) but the risk for a suicide death is rarer (about 1 in 10,000). The Surgeon General’s Call to Action lists risk factors for all ages as:

# Bio-psycho-social

Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders

Alcohol and other substance abuse disorders

Hopelessness

Impulsive and/or aggressive tendencies

History of trauma or abuse

Some major physical illnesses

Previous suicide attempt

Family history of suicide

**Environmental**

Job or financial loss

Relational or social loss

Easy access to lethal means

Local clusters of suicide that has a contagious influence

# Socio-cultural

Lack of social support and sense of isolation

Stigma associated with help-seeking behavior

Barriers to accessing health care, especially mental health and

 substance abuse treatment

Certain cultural and religious beliefs (for instance, the belief that

 suicide is a noble resolution of a personal dilemma)

Exposure to, including through the media, and influence of others

 who have died by suicide

Additional risk factor information may be found at www.suicidology.org.

3. How can school personnel help students who are at risk?

School personnel can be helpful to students who are at risk for suicide by offering care and support. Encouragement and attention from a teacher can break the sense of isolation that often accompanies suicidal ideation. All adults working with school children, including support staff, can help students develop coping skills and should become aware of the suicide risk factors and warning signs enabling them to identify a student who is thinking about suicide. The next step is to express concern and ask what the student’s intent is. School procedures will require all school personnel to refer a suicidal individual to someone trained in suicide prevention or a mental health professional who will then provide crisis counseling and notify the parents.

The school counselor has additional responsibilities when a suicidal student is referred to the counseling office. At least one counselor on staff needs to have crisis intervention counseling skills, be able to assess the risk that an attempt will be made, and to be familiar with community resources to refer the family.

The administrator’s role is to provide staff development opportunities for counselors to receive crisis intervention training and for all the staff to receive suicide awareness training that includes suicide warning signs and school policies and procedures.

The school nurse is often the first to be aware that a student may be considering suicide because students may seek out a nurse when they are not feeling well. All suicide attempters need to be seen by the school nurse, if there is one available, prior to being sent for additional medical attention outside the school.

4. What is the school counselors’ role when a student does complete suicide?

The school counselor has a vital role in the postvention efforts following a completed suicide on or off campus. The objectives of postvention activities are to prevent contagion and to get emotional and practical help for those students and staff that need it. If the school has a crisis team, the counselor is usually a member of the team and helps carry out the strategies of the school’s crisis plan. The counselor should be knowledgeable of crisis management best practices and postvention strategies and contribute to the development of school crisis plans.

The counselor can be most helpful in identifying students who are close friends and classmates who may need grief counseling either individually or in a group. A community resource list, both private (when permitted by the school district’s policies) and non-profit, needs to be kept current. Postvention guidelines will recommend forming structured support groups and following the deceased child’s schedule to meet with classmates. The counselor can check on vulnerable students and those who have attempted or threatened suicide in the past because a completed suicide of a classmate heightens the risk of an additional suicide.

The counselor may be involved in other assignments following a death such as assisting the principal in writing a letter to parents, making a home condolence visit, offering counseling support for fellow staff, raising awareness of suicide warning signs, helping to plan any school donations following suicide postvention principles and attending the funeral. For further postvention guidelines see the AAS Postvention Guidelines document.

The above responsibilities would be difficult for a counselor who knew the student personally and is mourning the loss. In that case, it would be best for a counselor from another school or another trained crisis team member to step in for the counselor.

5. How can schools and communities work together to prevent suicide?

The Centers for Disease Control recommends that each community form a central committee or task force of local leaders and agencies to address suicide prevention. Local mental health agencies, crisis centers, clergy, health departments, medical organizations, injury prevention agencies, the schools and other interested community entities should develop goals and strategies to prevent suicide.

The first step of the committee would be to conduct a surveillance of suicide attempts as well as completions. This can help identify community problems and create solutions that may bear on youth suicide. The committee can then become an advocate on issues affecting young people by recommending changes in the community’s environment. Some areas have a Child Death Review Team that serves in this function.

The committee could organize community suicide awareness sessions and promote training for the community mental health and medical professionals.

Community members may have expertise in suicide prevention that could be shared with the schools during staff development. Joint efforts to promote family education and child development are helpful. The committee can work with the schools to ensure the availability of treatment facilities and other referral resources for at-risk students. The committee could also be available to assist with postvention efforts to respond to attempts and completions.

6. What percentage of school aged children commit suicide?

Suicide is the third leading cause of death for ages 15-24 and the third leading cause of death for children 10-14 years old. These figures may be an underestimate of the actual numbers. There were 3,971 suicides between the ages of 15-24 in 2001, 10.9 each day or one every 2 hours and 12 minutes. The rate among children aged 10-14 is 1.6 per 100,000, the rate for children aged 15-19 is 9.7 per 100,000, and the rate for young people aged 20-24 is 14.5 per 100,000. You can expect around one teenage suicide a year for a school district with a high school enrollment of 9,700.

7. What do I do if a student tells me they want to commit suicide?

Counselors should take the threat seriously and spend time responding to a student’s disclosure of suicidal intention with sound crisis intervention counseling techniques. Crisis counseling techniques include active listening to the emotions. Active listening decreases the intensity of the emotions and forms a trusting relationship between the counselor and student. Many counselors learn how to do an initial assessment of risk for a suicide attempt. A high risk assessment would indicate the necessity of emergency protection for the suicidal student. A “no-suicide contract” may be used to put off a suicide attempt and to solidify the counselor’s commitment to help. However, even if a “no-suicide” contract is made, seeking further help is usually indicated. Parents always need to be notified and involved in the action plan unless there is suspicion of child abuse. Child Protective Services (Child Welfare Agency) must be contacted if there is suspicion that notifying parents would increase the danger for the child. No student should be left alone until the parents have been notified and an action plan that addresses the source of stress is agreed upon with continuing support from the counselor. Referral to a community mental health professional is usually appropriate. Inform an administrator and document all decisions and actions taken.

8. What are the ethical obligations of school counselors once the youth has been identified as suicidal or has attempted or completed suicide?

Once a suicidal student has come to the attention of a school counselor, the counselor is ethically bound to carry out the school policies and procedures and to use his or her training and skills to prevent the suicide attempt. This includes not leaving the student alone, notifying the parents, assisting with referrals to seek additional help and completing the necessary documentation. If there is a completed suicide the counselor must assist those who are affected by the death and counsel those who are most vulnerable to prevent additional suicides.

There is no ethical obligation to keep the suicide threat, attempt or completion confidential. The school counselor may decide to disclose this information on a need-to-know basis.

9. How do schools work with parents to ensure that appropriate services are provided for a suicidal student?

It can be frustrating for the school to make a referral when the family decides not to take their child for further help. Parents may not have the funds, ability to provide transportation to the services, trust mental health professionals and/or simply not have the time because they are working two jobs and have other siblings to care for. Sometimes the parents do not believe the child is going to carry out the threat and is just trying to get attention.

The counselor should try to convince the parents that the situation is dangerous and that they have an obligation to get help. The counselor needs to provide a community referral list of mental health providers and help make arrangements for the appropriate services, both public and private, if the school district permits private referrals. It is preferable for the family to make their own follow-up appointment, though there may be circumstances, with the parent’s permission, that the counselor will need to make contact with the referring agency and schedule the initial visit. Ask the parents to let the school know when an appointment is made and to check in after the first appointment to let the counselor know how it went. Get written permission from the parents to communicate with the mental health provider.

The counselor’s role then becomes supportive. It is not the school’s responsibility to provide therapy. However, if the parents do not get help and the counselor thinks there is continuing danger because of high risk, the family can be reported to the authorities or child protective services for neglect.

**10. Can the school, district, and/or counselor be sued by families after an attempted or completed suicide?**

The school district and the individual counselor (or other school staff) are legally in jeopardy if the district’s policies and procedures are not followed. Families can always bring suit but rarely win. Ordinarily, public schools are immune from legal recourse. Private schools are not as well protected. Of the few cases that have been won by families it is when the parents have not been notified of a threat or attempt. However rare these lawsuits are, the counselor needs to be prudent by following the school policies and documenting actions that were taken.

11. What are the different ethnic and gender rates of suicide attempts and completions?

The National Center for Health Statistics reports the following rates per 100,000:

 White Male………………………19.5

 White Female………………….….4.6

 Nonwhite Male……………..……..9.3

 Nonwhite Female………………….2.1

 Black Male………………………...9.2

 Black Female……………………....1.7

 Hispanic……………………………5.0

The “Surgeon General’s Call to Action To Prevent Suicide” indicates that males under the age of 25 are much more likely to commit suicide than their female counterparts. The gender ratio for people aged 15-19 is 5:1 (males to females). The reverse is true for suicide attempts. Females attempt suicide around 3 times more often than males.

12. What methods do those attempting and completing suicide most often use? How do these methods vary by gender?

Almost 65% of suicide deaths are committed with firearms. Weapons are lethal and do not leave much chance for intervention. Boys are more likely to use a gun and girls choose drug overdose more often. That accounts for some of the difference in suicide rates between the genders because drugs are not as lethal. A recent alarming trend for girls is the increase in hanging as a means of suicide.

13. What role does the media play, specifically in copycat suicides?

Research indicates a connection between certain ways of reporting and an increase in suicides. In the vast majority of instances, reporting a suicide by the media will not result in a copycat suicide. A consortium of agencies dedicated to the prevention of suicide has published a document, “Reporting on Suicide: Recommendations for the Media”. A copy of the full report can be found on the AAS website: [www.suicidology.org](http://www.suicidology.org). Research found an increase in suicide by readers or viewers when:

* The number of stories about individual suicides increases.
* A particular death is reported at length or in many stories.
* The story of an individual death by suicide is placed on the front page or at the beginning of a broadcast.
* The headlines about specific suicide deaths are dramatic.

14. Are there certain times of the year that have higher suicide rates?

Yes, but it is very slight. Contrary to popular belief, the suicide rate does not increase during the Christmas holidays. There is a small increase in spring.

15. What can be done to reduce the stigma of suicidal and depressed students?

This objective is one of the national strategies for suicide prevention. Schools could look to the county or state public health department, mental health association, or mental health and mental retardation agency for leadership. The strategy would be to increase the availability of information through public awareness campaigns including public service announcements, spokespersons, brochures and conferences. The message is that mental health is fundamental to overall good health and mental illnesses do respond to effective treatment. Suicides should not be normalized nor be viewed as a failure.

16. What screening and prevention programs have been proven effective?

There needs to be further evaluation and research to prove the effectiveness of school suicide prevention programs. The Center for Substance Abuse Prevention Model Programs and the Department of Education Best Practices has outlined dimensions for choosing effective prevention programs: http://www.modelprograms.samhsa.gov.

The Task Force for Child Survival and Development has identified 37 exemplary practices in “Next Steps”. <http://www.taskforce.org>. The programs are listed according to their focus:

1. School as environment/organization
2. School curriculum and educational activities
3. School as access point
4. School as service provider
5. Special needs schools

Programs that take a comprehensive approach seem to be most effective. These programs involve suicide awareness and gatekeeper training, policies and procedures, and community outreach. They include prevention, intervention and postvention efforts. The more successful programs are supported by the administration, include experts in prevention and have the commitment of the whole staff. Programs that attempt to do only one aspect of prevention often have limited or no demonstrable changes and are often short lived.

17. What is the relationship between mood disorders and suicide?

There is a connection between mood disorders and suicide. Over 90% of suicide victims have a significant diagnosable mental disorder at the time of their death. These are often undiagnosed, untreated or both. (See #2 above.) However, the vast majority of youth with a mood disorder will not die by suicide. Over the life time of adults, those with clinical major depression have about a 15% chance that they will kill themselves.

18. Are LGBTQ youth at high risk for suicide?

Yes. The exact risk is somewhat controversial. According to the Surgeon General’s “Call to Action to Prevention Suicide”, it has been widely reported that gay and lesbian youth are two to three times more likely to commit suicide than other youth and that 30% of all attempted or completed youth suicide are related to issues of sexual identity. There are no empirical data on completed suicides to support such assertions, but there is growing concern about an association between suicide risk and bisexuality or homosexuality for youth. LGBT youth have many additional stressors, often related to coming out or to being harassed.

19. What biological factors increase risk for suicide?

A decrease in the neurotransmitter, serotonin, has been proven to increase the likelihood of depression which is related to high risk for suicide. Identical twins reared apart have a higher correlation for suicide than the general population. There may be some brain abnormalities and hormonal combinations that are related to suicide. Research in this area is promising.

20. Does alcohol and drug use/abuse increase the risk for suicide among youth?

Yes. Drug use and substance abuse are highly correlated to the risk for suicide, especially among youth.