University of Pittsburgh
Office of Child Development

Children, Youth & Family

background

Report # 6 **Suicide Intervention** **Winter 1998**

Responding to Suicide

School-based intervention is found to be effective in easing recovery and preventing suicidal behavior from spreading among classmates

An adolescent's suicide can spread through a community like a contagion, sowing despair among friends and classmates as well as provoking thoughts of attempting suicide.

In its most tragic manifestation, an adolescent suicide will trigger an outbreak of suicidal behavior such as the one reported in Massachusetts last year, when six South Boston youths took their own lives over a seven-month period and another 70 were hospitalized for attempted suicide or other suicidal behavior.

The South Boston tragedy and others like it show how an adolescent's suicide can become a community-wide crisis. Such a crisis, experts say, demands a community-wide response. And the best place to base a suicide intervention program is in the school around which the lives of most adolescents revolve.

Models for a school-based suicide intervention plan are offered by several organizations, including the Centers for Disease Control, the American Association of Suicidology, and the University of Pittsburgh. In general, school-based interventions attempt to:

- Dispel rumors that often follow an adolescent's suicide.
- Enable students to grieve appropriately.
- Identify those experiencing difficulty dealing with the suicide and refer them to mental health treatment.
- Provide students with a stable environment that acknowledges the death and their grief but also allows for a return to normal routine as soon as possible.

One Suicide, Many Risks

An adolescent's suicide is particularly hard on friends and close classmates, leaving them vulnerable to attempting suicide themselves.

Friends of suicide victims are three times more likely to experience psychiatric disorders, such as depression. And any pre-existing conduct problems and drug and alcohol abuse problems they might have tend to worsen.[1] Reducing the risks to these and other students is the goal of school-based intervention.

One major advantage of such a plan is that an intervention strategy is worked out beforehand, rather than in the heat of crisis, so a crisis team can swing into action immediately. A crisis response team consists of the most clinically-trained staff available, includeing psychologists, counselors, and nurses. Outside specialists may be included. An administrator, often the superintendent, leads the crisis response effort.

When word of a student's suicide reaches a school, the crisis intervention team is mobilized.

Crisis Response

Among their first jobs is contacting agencies and others whose expertise can be used to help ease students through the crisis. These contacts include the coroner, who can provide facts of the death helpful in dispelling rumors, and mental health agencies which can break the news of a suicide to students, identify troubled students, and operate support groups.

*For more on suicide risk factors see the **background** report, **Adolescent Suicide** (Report #5, Winter 1998)*

Parents of the victim are contacted by the crisis team coordinator. This allows the school an opportunity to express condolences and also to check on how the family is holding up and whether support or treatment is needed.

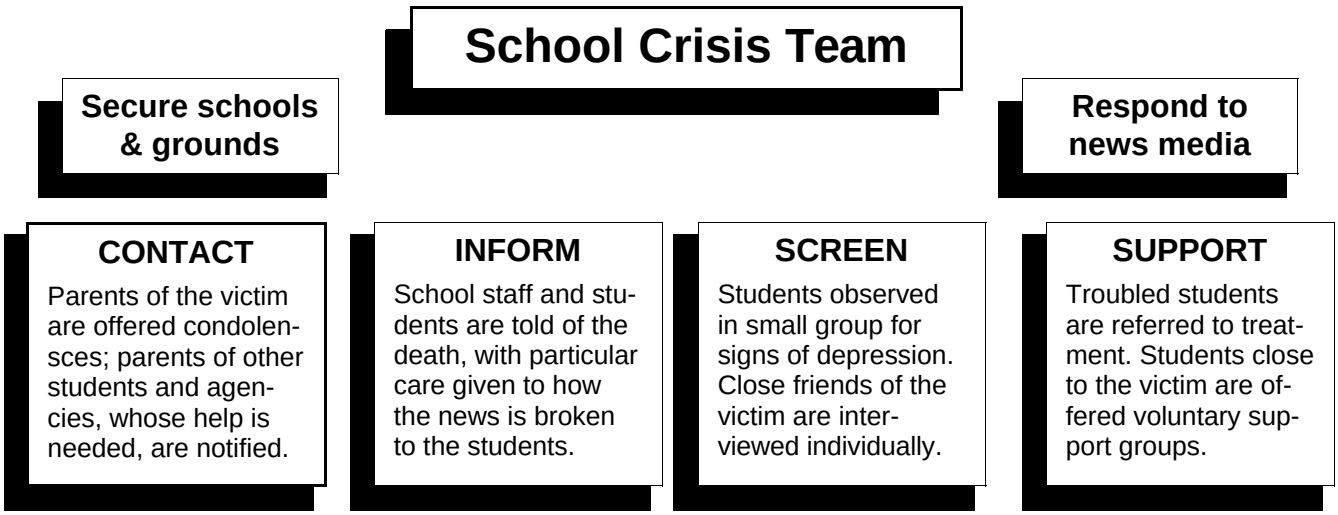
Parents of surviving students are informed of the death and the interventions that are underway by letter.

How students are informed of a suicide is very important.

First, they are told as early as possible and told in small groups that allow staff to monitor their reactions. In the groups, they are encouraged to ask questions, are briefed on the warning signs of depression and suicidal behavior, and are told how and where they can get help.

(Continued on back)

A School Response To Suicide



(Continued from front)

Screening For Trouble

School staff are instructed to pay close attention to students during the group sessions, looking for signs of psychological disorders, such as depression or post-traumatic stress disorder. When symptoms are seen, the student is referred to treatment. The most vulnerable students get additional attention. Crisis workers, for example, separately interview those who were close to the victim and students with a history of psychological disorder or attempted suicide.

In addition to treatment, voluntary support groups are offered to students and teachers. These groups provide time to share feelings, express emotions and concerns, correct misinformation, ease the sense of responsibility for the death those close to the victim may feel, and generally help them grieve appropriately.

Striking a balance between a caring response and one that tends to glorify a student's suicide is important. Memorials to the victim, for example, are generally discouraged. No matter how well intentioned, a memorial risks glorifying the manner of the student's death and possibly validating suicide in the minds of troubled students.

News Media

Most school-based intervention plans recommend a strict news media policy. A primary responsibility of the crisis team is to secure an environment in which students and staff can grieve and begin the healing process. Consequently, schools are made off-limits to those not involved in the intervention plan, including reporters.

School officials are instructed not to comment on many aspects of a suicide, particularly the method of death. The reason behind such silence is that publicity of a adolescent's suicide is considered a threat to other students, one of several factors that might lead others to attempt to harm themselves.

But some news coverage is helpful. Stories that explain the interventions underway, the warning signs of depression and suicidal behavior, or report where to get treatment or support help students, parents, and the community at-large recover from the tragedy of a young person's suicide.

References

Brent, D.A., Kerr, M.M., Bozigar, J.A., & McQuiston, L. A school-based response to traumatic student death. In Nader, P.R. (Ed.); *School Health: A Guide for Health Professionals,* (Fourth Edition), 206-227. American Academy of Pediatrics, 1987.

[1] Brent, D.A., Perper, J.A., & Moritz, G.M. (1993). Psychiatric effects of exposure to suicide among the friends and acquaintances of adolescent suicide victims. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 629-640.

———

David A. Brent, M.D., Professor of Child Psychiatry, Pediatrics, and Epidemiology at the University of Pittsburgh can be reached by contacting Craig Dunhoff at the University of Pittsburgh Medical Center News Bureau, (412) 624-2607.

Children, Youth & Family **background** is published by the University of Pittsburgh Office of Child Development, a program of the University Center for Social and Urban Research. Reports are based on available research and provided as overviews of topics important to children and families.

Co-Directors: Christina J. Groark, Ph.D.; Robert B. McCall, Ph.D. **Associate Directors**: Carl N. Johnson, Ph.D.; Marks S. Strauss, Ph.D. **background Editor**: Robert B. McCall, Ph.D.; **Writer**: Jeffery Fraser (412) 731-6641, e-mail: fraser53@msn.com

Office of Child Development, University of Pittsburgh, 2017 Cathedral of Learning, Pittsburgh, PA 15235; fax: (412) 624-1187