DOCUMENT RESUME

ED 362 818 CG 025 088

AUTHOR Laws, Kathy; Turner, Amy
TITLE Alcohol and Other Drug Use: The Connection to Youth Suicide. Abstracts of Selected Research.
INSTITUTION Texas Early Childhood Intervention Program, Austin.
SPONS AGENCY Department of Education, Washington, DC.
PUB DATE Aug 93
CONTRACT S188A00001
NOTE 83p.
PUB TYPE Reference Materials - Bibliographies (131)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS Adolescents; *Alcohol Abuse; Drinking; *Drug Use; *Prevention; Substance Abuse; *Suicide; *Youth Problems

ABSTRACT

This publication provides the reader with an overview of the research done on the connection between the use of alcohol and other drugs and the ideation and/or completion of suicide among adolescents. It also provides information and resources on how to develop a youth suicide prevention program. The introduction gives a brief overview of the significance of the problem of youth suicide and identifies nine key issues that emerge from the research on the connection between adolescent substance use and suicide. This section is followed by a list of warning signs for adolescent suicide. The body of the publication contains abstracts of 39 research articles that provide an overview of the link between alcohol and other drug abuse and youth suicide and that present a review of what some schools and communities are doing in regard to suicide prevention, intervention, and postvention. Articles are divided into two sections. The first section, Studies on Adolescent Suicide and Substance Abuse, contains abstracts of 19 articles. The second section, Suicide Prevention, Intervention, and Postvention In the Schools, contains abstracts of 20 articles. Articles are organized alphabetically by author in each section. Following the abstracts are the subject index of keywords; the reference section; and the resource listing of curricula, manuals, program development materials, and organizations. (NB)

Western Regional Center
DRUG-FREE SCHOOLS AND COMMUNITIES

Alcohol and Other Drug Use: The Connection to Youth Suicide Abstracts of Selected Research

August 1993

Northwest Regional Educational Laboratory
101 S.W. Main Street, Suite 500
Portland, Oregon 97204

Far West Laboratory for Educational Research and Development
730 Harrison Street
San Francisco, California 94107-1242

The Southwest Regional Educational Laboratory
4665 Lampson Avenue
Los Alamitos, California 90720

Western Regional Center for Drug-Free Schools and Communities
Judith A. Johnson, Director

Northwest Regional Educational Laboratory
101 S.W. Main Street, Suite 500
Portland, OR 97204
(503) 275-9500

Field Office
828 Fort Street Mall, Suite 500
Honolulu, Hawaii 96813
(808) 533-6000

Far West Laboratory for Educational Research & Development
730 Harrison Street
San Francisco, CA 94107
(415) 565-3000

Southwest Regional Laboratory
4665 Lampson Avenue
Los Alamitos, CA 90720
(310) 598-7661

The contents of this publication were developed under Cooperative Agreement Number S188A00001 with the U.S. Department of Education. However, the contents do not necessarily represent the policy of the Department of Education, and endorsement of the contents by the federal government should not be assumed.

Alcohol and Other Drug Use: The Connection to Youth Suicide Abstracts of Selected Research

by

Kathy Laws
Western Regional Center for
Drug-Free Schools and Communities

Amy Turner
St. Thomas More School
Portland, Oregon

Northwest Regional Educational Laboratory
101 S.W. Main Street, Suite 500
Portland, Oregon 97204

August 1993

Acknowledgments

The material abstracted in this publication was collected, summarized, and indexed with the combined efforts of Kathy Laws, Information Specialist for the Western Regional Center and Amy Turner, an Intern Research Assistant and teacher from St. Thomas More School.

This publication is intended to give the reader an overview of the research done on the connection between the use of alcohol and other drugs and the ideation and/or completion of suicide among adolescents as well as provide information and resources on how to develop a youth suicide prevention program. In the recent U.S. Department of Education publication, ***Youth & Alcohol, Selected Reports to the Surgeon General,*** it notes that "suicide among American teenagers is increasing at an alarming though underestimated rate" and that "alcohol acts as a contributing factor in the timing and seriousness of youth suicide attempts."

It is hoped that this collection will help parents, educators, health professionals, and others who work with young people to understand the issues surrounding this topic and to identify the steps necessary to provide for the prevention and intervention of adolescent suicide.

Judith A. Johnson, Director
Western Regional Center for Drug-Free School and Communities

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Introduction

Youth suicide has become a significant social issue touching the majority of young people in the United States. Educators, mental health professionals, youth service providers, parents and government policy makers are being challenged to take a proactive stance toward this issue and to develop and implement policies and programs for the prevention of suicide among our youth.

Many of us are already aware of the alarming statistics attributed to youth suicide. Approximately 2,200 youth between the ages of 15-19 years of age took their lives in 1990 (Centers for Disease Control). That number more than doubles when the 20-24 year age group is added. The number of *attempted* suicides is even more disturbing--500,000 youth between the ages of 15-24 attempt suicide each year.

Those working in the alcohol and other drug (AOD) field are already aware of the strong connection between alcohol and other drug abuse and youth suicide and the implications that this connection has on AOD prevention, intervention and treatment efforts. Substance abuse problems are frequently associated with completed and attempted suicides as well as with suicidal ideation among adolescents. Reports from hospital emergency rooms in major metropolitan areas find that over 60 percent of 10 to 17 year olds' drug related medical emergencies are actually suicide attempts. One research study found that at least one-third of teens who commit suicide are intoxicated at the time of death and many more may be under the influence of drugs.

Schools and communities continue to grapple with how best to confront the youth suicide problem. What kind of suicide prevention program to implement, who should receive this kind of program, what types of prevention programs are effective, and what intervention policies and programs should be implemented are questions that need to be addressed.

Thirty-nine research articles were abstracted for this publication in order to give an overview of the link between alcohol and other drug abuse and youth suicide and to provide a review of what some schools and communities are doing in regards to suicide prevention, intervention and postvention. Following the abstracts are the subject index of keywords, the reference section, and the resource listing of curricula, manuals, program development materials and organizations.

From the research several key issues emerge: (1) Suicide is not limited or of concern to only a small segment of the adolescent population. (2) Ideators, attempters and completers share many of the same symptoms and risk taking behaviors including depression, low self-esteem, stress, and interpersonal problems. Among the risk taking behaviors, alcohol and other drug abuse is frequently noted as a major contributing factor in adolescent suicide. (3) It is important to identify and treat the conditions known to predispose children and teenagers to suicidal behavior before they succumb to suicidal ideation. (4) The use of alcohol or other drugs is predominant among suicide victims

who used firearms to take their lives. (5) A critical component of school policy is a suicide postvention plan that provides emergency crisis interventions and treatment after crisis. (6) Comprehensive mental health education programs are advocated that include not only school personnel but representatives from various community agencies. (7) There is no agreement as to whether to provide suicide prevention to the entire student body of a school or only to those students who have been identified at risk. (8) Extensive evaluation is recommended as there is no conclusive evidence as to the effectiveness of suicide prevention curricula and programs. (9) A strong case can be made for investing in primary prevention programs such as substance abuse prevention because these programs also help reduce dropping out, delinquency, violence and teen pregnancy as well as teen suicide.

The link between alcohol and adolescent suicide is clear as demonstrated by the research compiled for this publication. Schools and communities are called upon to meet the needs of young people by providing a well-thought out and comprehensive approach to suicide prevention and intervention.

References:

Ackerman, G.L. "A Congressional View of Youth Suicide." *American Psychologist*, 48(2) (1993):183-184.

U.S. Congress, Office of Technology. *Assessment Adolescent Health, Volume II: Background and the Effectiveness of Selected Prevention and Treatment Services.* Washington, D.C.: U.S. Government Printing Office, (1991).

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Warning Signs For Adolescent Suicide

Behaviors

Depression, indicated by persisting:
- Sadness.
- Lack of energy.
- Difficulty in concentrating.
- Loss of interest in usual activities.
- Atypical acting-out behaviors (i.e. anger, belligerence to authority figure, alcohol/ drug abuse, sexual promiscuity, and running away from home).

Wide mood swings from depressed to overly happy.

Lack of concern about personal welfare indicated through reckless driving, accepting "dares" from peers, experimenting with medication or "forgetting" to take prescribed medications.

Attempts to put personal affairs in order or to make amends.

Giving away personal possessions.

Writing a suicide note or making a will.

Use or abuse of alcohol or other drugs

Employing "all-or-nothing" thinking patterns and motivations.

Poor communication and problem-solving skills.

Themes of death or destruction in talk or reading or written materials.

Agitation, restlessness.

Collecting pills, razor blades, knives, ropes, or firearms.

Angry and explosive outbursts.

Antisocial behaviors such as fighting, violent outbursts, stealing and vandalism.

Changes

Can't concentrate on school, work, routine tasks.

Decline in school achievement.

In social patterns: becoming either more withdrawn, tired, apathetic, indecisive, or more boisterous, talkative, outgoing.

In sleep pattern--either excessive increase or decrease.

In eating habits--loss of appetite and weight or overeating.

Loss of interest in friends, hobbies, personal grooming, or activities previously enjoyed.

Sudden improvement after a period of being down or withdrawn --often results from the teen having settled on a decision to commit suicide.

Sudden or increased promiscuity.

Feelings, either expressed or perceived

Low self-esteem.

Feelings of hopelessness, helplessness, worthlessness, overwhelming guilt, shame, and/or self-hatred.

Fear of losing control, going crazy, harming self or others.

Pervasive sadness.

Persistent anxiety or anger.

Making threats:
- Asking, for example, "How long does it take to bleed to death?"
- Statements such as, "I won't be around much longer."

Verbal remarks about sense of failure, worthlessness, isolation, absence, or death; also written stories, essays, or art projects depicting the same themes.

Circumstances

Experienced a recent loss:
- Death of a family member or friend.
- Divorce of parents.
- Breakup with boyfriend or girlfriend.
- Separation from one or both parents, siblings or friends.
- Loss of status through reduced parental financial status.

Failure in school.

Social isolation and lack of close friends--even though the teen may have superficial contact with a group of peers.

Disharmony or disruption in the family.
- Substance abuse by family members.
- Physical or sexual abuse.

Has previously undergone psychiatric treatment.

Previous suicide attempts.

Has been humiliated by peers.

Has recently been severely disciplined by family or school officials.

Has been sexually assaulted.

Learning disabled and emotionally disturbed students.

Changing to a new school.

Studies on Adolescent Suicide and Substance Abuse

1. Adcock, A.G., Nagy, S., and Simpson, J.A. "Selected Risk Factors in Adolescent Suicide Attempts." *Adolescence*, 26(104) (1991):817-828.

Data on stress, depression, attempted suicide and related behaviors among eighth and tenth graders were collected in Alabama as part of the Alabama Adolescent Health Survey (AAHS), a follow-up to the 1987 National Adolescent Student Health Survey (NASHS). The purposes of this study were: (1) to compare AAHS responses to the national data set; (2) to examine the influence of gender, race, locale, and high-risk behaviors (alcohol use and sexual activity) on self-reported levels of stress, depressions, and suicide attempts; and (3) to determine the level of knowledge of common signs of suicide among Alabama adolescents.

Sixty-two percent of the males and 38% of the females had engaged in sexual intercourse at least once, while 54% of the males and 38% of the females had consumed alcohol at least once during the previous month. Blacks had a higher rate of sexual experience than whites, while alcohol consumption was higher for whites. Students who engaged in both behaviors (participants) comprised 27% of the sample, while students who engaged in neither (abstainers) made up 35% of the sample. More males (34%) than females (21%) were participants, as were approximately 25% of both whites and blacks. More females (44%) were abstainers than males (26%), as were more whites (40%) than blacks (28%).

Participants in the high-risk behaviors of sexual intercourse and alcohol use were almost three times as likely as abstainers to have attempted suicide (25% vs. 9%). Both male and female participants were much more likely to have difficulty handling stress, to exhibit symptoms of depression, and to attempt suicide. White participants scored significantly higher on the four items than did abstainers, but black youth did not reflect the same degree of difference.

The findings suggest that many adolescents experience difficulty coping with stress and depression, and that students who are engaging in risk-taking behaviors are also at greater risk for depression and suicide. Educational and supportive interventions should take into account ethnicity and gender, and should address the multitude of adolescent problems (premarital pregnancy, substance abuse, suicide) in the context of a comprehensive program involving schools, families, health departments, and other community agents.

Keywords: Depression
Drugs (alcohol)
Ethnicity (Blacks)
Gender differences
Rural/urban aspects
Sexual intercourse
Stress

2. Andrews, J.A., and Lewinsohn, P.M. "The Prevalence, Lethality, and Intent of Suicide Attempts Among Adolescents." Paper presented at the 98th annual convention of the American Psychological Association, Boston, MA. (August 1990).

Although suicide is the second leading cause of death among adolescents in the United States, little is known about the prevalence or characteristics of suicide attempts among adolescents. Data from 1,710 adolescents attending nine high schools in five communities were examined to determine the prevalence of suicide attempts and the lethality and intent of the attempts. Each adolescent was interviewed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children form which combined the Epidemiologic version (K-SADS-E) and the Present Episode version (K-SADS-P).

Approximately 6.8% of the adolescents had attempted suicide in their lifetime. A significantly greater proportion of girls (9.8%) as compared to boys (3.5%) had attempted suicide. For both males and females, there was a significantly higher rate of attempts among adolescents with a diagnosis of major depression, substance use disorder, or disruptive behavior disorder than among adolescents without such diagnoses. Of these attempts, 14% were rated as potentially lethal and 43% were considered intentional. An examination of the relationship between lifetime attempts and lifetime psychiatric disorders revealed that a large proportion of adolescents who attempted suicide had a history of a psychiatric disorder. The results also indicated that being female and being from a home with no male head of household were risk factors for a suicide attempt.

Keywords: Depression
Family aspects
Gender differences
Psychiatric disorders

3. Andrus, J.K., Fleming, D.W., Heumann, M.A. et al. "Surveillance of Attempted Suicide among Adolescents in Oregon, 1988." *American Journal of Public Health*, 81(8) (1991):1067-1069.

In January 1988, Oregon became the first state to require hospital-based reporting of attempted suicide in all adolescents younger than 18 years old. The data from the first year of this required reporting are summarized. The characteristics of the adolescent suicide attempters in 1988 are compared with those adolescents who completed suicide during the period 1979-1988.

Results indicated that in 1988, 644 adolescents aged 10 to 17 years were reported by a hospital to have attempted suicide. This is an annual incidence rate of 214 per 100,000. Of these attempters, 87.7 % were aged 14 to 17 years, 83.5% were female, and 84.9% were white. Attempters most frequently used the methods of drug overdose (75.5%) and laceration (10.4%).

In comparison, 137 adolescents completed suicide from 1979 to 1988, 80.3% of whom were male, and 92.6% of whom were white. Completers most frequently used the methods of firearms (72.3%) and hanging (16.8%). Method of suicide attempt was the overwhelming predictor of outcome of the attempt, with those using guns and hanging generally dying and those using drugs or laceration generally living.

The blood alcohol levels were tested for only 9.5% of the attempters and 41.6% of the completers. Of those tested, among the attempters 50.8% had detectable blood alcohol levels; among the completers tested, 35.1% had documented detectable blood alcohol at the time of death.

Keywords: Drugs (alcohol)
Firearms
Gender differences

4. Canetto, S.S. "Gender Roles, Suicide Attempts, and Substance Abuse." *Journal of Psychology*, 125(6) (1991):605-620.

Suicide attempts and substance abuse, traditionally considered separate, unrelated disorders, are compared in terms of their manifested features (phenomenology), psychological dynamics, interpersonal dynamics, incidence and prevalence (epidemiology), gender roles, theories of etiology (origin), and treatments.

Substance abuse and suicide attempt were described as manifesting similar characteristics, such as both involving self-inflicted potentially lethal physical harm and other self-harming behaviors. Also, both substance abuse and suicide attempts include episodes that are unplanned and impulsive.

Both substance abuse and suicide attempt were noted to share a number of psychological features, including having been associated with depression, problems with dependency or dominance in relationships, and problems in expressing and regulating aggression. Some of the personality traits used to describe suicide attempters and substance abusers are similar, with suicide attempters described as anxious, mistrusting, tense, insecure and self-critical, and substance abusers described as exhibiting anxiety, a negative self-concept, self-esteem defects, sensitivity to criticism, underlying insecurity, helplessness, impulsiveness, and low tolerance for frustration.

The author also notes differences between substance abuse and suicide attempts, especially in terms of their incidence and distribution by gender in the population: suicide attempts are more common--and more socially acceptable--among women, and substance abuse is more common among men. Differences between substance abuse and suicide were also found in their theories of origin and in their treatments. In the case of substance abuse, external stressors and constraints are most frequently named as originating factors, for instance in the theory that alcoholism is a disease and in the enabler theory which stresses that family members and significant others enable the substance abuse. In cases of substance abuse, family therapy is more commonly applied. However, in suicide attempts, "personal inadequacies" such as a "faulty personality" are cited and individual therapy is generally applied.

It is argued that given these similarities and differences between suicide attempts and substance abuse, they may be alternate and gender-specific forms of dealing with similar underlying intrapsychic and interpersonal difficulties. Potential benefits of not considering substance abuse and suicide attempts as two separate disorders but as equivalent behaviors are presented. It is suggested that innovations in research methods could result from integrating the theories currently supporting each disorder separately and that these integrated theories could prompt investigation of a broader range of treatments for both disorders.

Successful substance abuse interventions such as social skills training and stress management could be incorporated into treatment of suicidal individuals, and suicide-attempt treatments which generally focus on intrapersonal issues could be applied to substance abusers, leading to the abuser gaining greater self-understanding and self-esteem.

Keywords: Depression
Gender differences
Interpersonal factors
Self-esteem
Treatment strategies

5. Crumley, F.E. "Substance Abuse and Adolescent Suicidal Behavior." *JAMA: Journal of the American Medical Association*, 263(22) (1990):3051-3056.

This paper examines the research on adolescent substance use and abuse and suicidal behavior, citing evidence that there is an association. An example is the parallel rising rates in the past 20 years of psychoactive substance use (including alcohol use), especially among adolescent males, and the rise in suicide rates, again particularly for adolescent males. There is evidence supporting a hypothesis that substance abuse is a risk factor for not only completed suicide, but that it is also associated with increased suicidal behavior, including increased repetitiveness of suicide attempts, seriousness of intention, and medical lethality. However, evidence supporting a causal link between substance abuse and suicidal behavior has yet to be obtained.

The author cites the results of several studies which found alcohol or drug use to be a risk factor in completed youth suicides. One study of 229 suicide victims younger than 19 years old between 1975 and 1985 indicated that 22% were either drug abusers (10%) or alcohol abusers (12%) and that males were more likely than females to be substance abusers but that females were more likely to have a current depressive disorder. This study concluded that young people most at risk for suicide were males who are alcohol abusers and females who were depressed and all of whom had experienced a precipitating event such as a social loss or a blow to their self-esteem.

Another study of completed suicides between 1970 and 1985 reported that 45% of the adolescent suicide victims used drugs or alcohol at the time of death and that at least 27.9% of the adolescent suicide victims showed indications of having a previous history of substance abuse. Alcohol abuse was found to be the most common risk factor for suicide in another study, this one of 190 Canadian suicide victims younger than 21 years old. Alcohol abuse was found in 37% of the victims, and abuse of other drugs was found in 17%. Further evidence of an association between substance abuse and suicide comes from a study of 104 youth suicide victims in New York City. This study employed a control group and determined that 37% of male suicides and 5% of female suicides showed evidence of substance abuse while 7% of the males and females in the control group showed evidence of substance abuse. The study concluded that substance abuse was the third most important risk factor for suicide among adolescent males (after previous suicide attempts and major depression) and that substance abuse was the fourth most important risk factor among adolescent females (following suicide attempts, major depression, and antisocial behavior).

The association between substance abuse and suicidal behavior including repetitiveness, seriousness of suicidal intention and lethality is observed in several studies. One study of 64 hospitalized youth included 33 who had made at least one suicide attempt prior to admission and found a significant association between alcohol abuse and all four dimensions of suicidal ideation and behavior: number of suicide attempts, seriousness of attempts, medical lethality, and suicidal tendencies. This study concludes that substance abuse occurring with major depression in an adolescent appears to increase the risk of

multiple attempts and medically lethal attempts. Another study which looked at the medical charts of 200 hospitalized adolescents indicated that alcohol abuse was one of the best predictors of the "severity of suicidal behavior."

The literature on substance abuse in relation to depression and/or conduct and personality disorders is explored. including borderline personality disorder and bipolar affective disorder (manic depressive disorder) because these disorders in combination are frequently mentioned in psychological profiles of adolescents at risk for suicide. The findings suggest evidence of an interconnection between alcohol and other drug abuse and suicide ideation, attempts, and completions, especially when that substance abuse occurs along with depression, personality, and conduct disorders.

Suggestions for clinical application of these findings are that teens known to abuse alcohol and other drugs should be carefully monitored for depression and suicidal impulses. Moreover, adolescents experiencing suicidal tendencies or depression need to be considered as potential substance abusers. Finally, another strategy when presented with a potentially suicidal adolescent would be to ask about access to firearms and recommend their removal from the home as the availability of firearms at home has been shown to be much greater with suicide completers than in those of comparable groups of at-risk youth.

Keywords: Depression
Drugs (alcohol)
Firearms
Gender differences
Intervention
Psychiatric disorders
Treatment strategies

6. Felts, W.M., Chenier, T., and Barnes, R. "Drug Use and Suicide Ideation and Behavior among North Carolina Public School Students." *American Journal of Public Health*, 82 (1992):870-872.

Substance abuse is frequently noted to be a risk factor for adolescent suicidal ideation and behavior (along with previous suicide attempts, illness, family violence, and precipitating events). The authors suggest that understanding the connection between substance abuse and youth suicide can help health educators design effective intervention strategies. The purpose of this study was to determine if a relationship exists between suicidal ideation/behavior and substance abuse, and if so, to outline the nature of that relationship.

The data for this study were collected as a part of a larger study of health risk behavior of North Carolina students, in which the Youth Risk Behavior Survey was administered. Results of the study were "consistent with the hypothesis that increased drug use, early onset of drug use, or both is associated with a greater tendency to think about or actually attempt suicide," although the data were not able to point to a precise cause-and-effect relationship between drug use and suicidal behavior. It was found that "the use of cocaine/crack was more closely associated with self-reported incidence of attempted suicide than was use of alcohol, marijuana, or needle drugs." And "use of cocaine/crack, alcohol, or marijuana was significantly related to a student's report of seriously thinking about attempting suicide or making specific suicide plans."

Keywords: Drugs (cocaine)

7. Garrison, C.Z., McKeown, R.E., Valois, R.F., and Vincent, M.L. "Aggression, Substance Abuse, and Suicidal Behaviors in High School Students." *American Journal of Public Health*, 83 (1993):179-184.

The Youth Risk Behavior Survey was administered to 3,764 South Carolina high school students to estimate the prevalence of suicidal thoughts, plans, attempts requiring no medical care, and attempts requiring medical care in a community sample of adolescents. The rates of these various types of suicidal behaviors in males and females were compared, and suicidal behaviors were explored in relationship to aggressive behaviors, cigarette, alcohol and other drug use, and physical recklessness.

Results were that 75% of students reported no suicidal behaviors, 11% reported serious suicidal thoughts, 5.9% reported attempts not requiring medical care, and 1.6% reported attempts requiring medical care. All types of suicidal behaviors occurred more frequently in females than in males. Aggressive behavior was associated with all four types of suicidal behavior even when alcohol and illicit drug use were controlled for. Odds ratios for aggressive behaviors and cigarette use were elevated across all categories of suicide behaviors, increasing in magnitude with severity of reported suicidal behavior. Substance use was associated with some but not all categories of suicidal behaviors. The relationships were most pronounced with the reported use of the potentially more dangerous or "harder" drugs.

Conclusions are that if high-risk behaviors such as substance abuse and aggression are identified, the adolescent should also be carefully assessed for suicidal behaviors. Also, suicide prevention efforts should perhaps target a range of behaviors, including substance abuse and aggression.

Keywords: Aggression
Drugs (tobacco)
Gender differences

8. Grossman, D.C., Milligan, B.C., and Deyo, R.A. "Risk Factors for Suicide Attempts Among Navajo Adolescents." *American Journal of Public Health*, 81 (1991):870-874.

Rates of adolescent suicide in the United States are highest among Native Americans. The suicide rate among Native American adolescents in 1987 was 26.8 per 100,000, more than double the national rate of adolescents of all races. This study tests the risk factors for suicide considered to be important in the general population against a sample of Navajo adolescents. Data was collected using the 1988 Indian Health Service Adolescent Health Survey, administered to 7,254 students in grades 6 through 12 on the Navajo reservation.

Results indicate that nearly 15% reported a previous suicide attempt; over half of those admitted to more than one attempt. Similar to the general population, the two risk factors with the strongest associations to suicide attempts were a history of a mental, behavioral, or emotional problem requiring professional help and extreme alienation from family and community. Also having strong associations with suicide attempts were exposure to suicide completions and attempts by family and friends and consumption of hard liquor at weekly intervals. Beer and wine consumption were not significant correlates. Other risk factors associated with suicide attempts were a self-perception of poor general health, past physical abuse, and sexual abuse.

Keywords: Alienation
Drugs (alcohol)
Ethnicity (Native Americans)
Family aspects

9. Hoberman, H.M., and Garfinkel, B.D. "Completed Suicide in Children and Adolescents." *Journal of the American Academy of Child and Adolescent Psychiatry*, 27 (1988):689-695.

Data were obtained from medical examiners on all nonnatural deaths of children and adolescents in the Minneapolis area for 1975 through 1985, and 229 youth suicides were identified. Fifteen percent of those suicides had not been so determined by the medical examiner. Most of the victims were between the ages of 15 and 19 (91%). Nine percent were 14 or younger. More males than females were among the victims (80%), and 94% of all victims were whites. (The overall population in that area is 89% white and 4% black.)

The method of suicide most frequently employed was firearms (in 42% of all cases) but was the leading method only for males (52%). Females more often employed ingestion (27%) and carbon monoxide poisoning (25%) and used firearms 21% of the time. There were also age differences in method: older completers used firearms 44% of the time followed by carbon monoxide poisoning (17%) while the majority (52%) of completers under age 14 hanged themselves, followed by use of a firearm (24%).

Findings on the circumstances of the youth suicides showed that most took place at the victim's home (70%) and that 62% of the victims had made a remark about suicide prior to their death, usually on the day of death. Alcohol had been consumed by 28% of the victims in the twelve hours before death, and in another 17% of the cases there were indications of "probable alcohol consumption." The research authors suggests that intoxication may indicate an attempt at disinhibition in order to commit suicide.

Stressors occurring within the three days prior to death were noted as possible precipitants. Arguments were the most common stressor (19%), followed by school problems (14%) and disappointments (11%). Generally, the precipitant occurred within 24 hours of death. However, the authors also note that "these stressors generally appear to be the same type of life events that occur for most adolescents."

The psychiatric histories of the victims were evaluated, revealing that 10% were alcohol abusers and 12% were drug abusers while 28% suffered from a depressive disorder at the time of death. Sixteen percent had past depressive disorders; 5% had past alcoholism and 11% prior substance abuse disorders. Depression and alcohol and other substance abuse are both "associated with a greater likelihood of suicidal ideation which in turn predisposes to suicide attempts," but "most depressed or substance abusing young people neither attempt nor complete suicide."

It is suggested that parents and teachers are not the best source of information on adolescents' depression or substance abuse. Therefore, medical examiners' reports may not accurately reflect rates in these areas because they are generally based on interviews with parents and teachers.

School-based prevention curricula designed for students that "focus on precipitants, signs of premeditation, or planning is likely to be unproductive given the normative nature of the stresses experienced by young suicides and the apparently impulsive nature of the actual suicidal act." It is suggested that emphasis be placed not on the circumstances surrounding suicides but that programs focus on identification and treatment of the "psychopathology that underlie and precede most instances of suicide in young persons." That is, that "programs are needed to train parents, teachers, and physicians to recognize depressive disorders and substance abuse in adolescents and make appropriate referrals."

Keywords: Drugs (alcohol)
Firearms
Gender differences
Interpersonal factors
Prevention strategies
Psychiatric disorders

10. Howard-Pitney, B., Basil, M., LaFromboise, T.D., September, B., and Johnson, M. "Psychological and Social Indicators of Suicide Ideation and Suicide Attempts in Zuni Adolescents." *Journal of Consulting and Clinical Psychology,* 60 (1992):473-476.

Suicide behavior is a significant problem for many American Indian populations, often more so than in the general population, but little tribal-specific data is available. In this study, baseline data on the correlates of suicide ideation and the social and psychological differences between suicide attempters and nonattempters were collected on a sample of 84 Zuni adolescents. The variables that were studied for connection to suicide ideation and attempt were depression, hopelessness, alienation from school, substance use, parental substance use, social support, problems in interpersonal relationships, communication abilities, and degree to which the student adheres to Zuni cultural norms and traditions.

Suicide is a forbidden act in Zuni culture, but results indicated that 30% of the students reported having tried to kill themselves. This is much higher than the 4-13% rate reported in the general adolescent population. However, 35% of those who attempted suicide never told anyone about the attempt. Similar to the general adolescent population, girls reported more suicide attempts than boys. A strong relationship was found between drug use and suicidal behavior, with attempters more likely than nonattempters to use alcohol and marijuana and 65% of attempters reporting that they got drunk once a month or more, while only 35% of nonattempters reported doing so.

Attempters showed higher suicide ideation, depression, hopelessness, and stress than nonattempters and reported fewer efforts at coping, less liking for school, fewer interpersonal communication skills, and less social support. Attempters were no different from nonattempters on perceived traditionality or concern about parent drug use.

Some implications of these results are that each of the correlates of suicidal ideation and behavior could form the core of prevention education and skills building programs for adolescent Indians. Areas in which adolescents need programs to build their skills are: effective communication; combating depression, hopelessness, and stress; gaining access to social support; and resisting substance use.

Keywords: Depression
Drugs (alcohol)
Ethnicity (Native Americans)
Family aspects
Interpersonal factors
Prevention strategies
Stress

11. Kinkel, R.J., Bailey, C.W., and Josef, N.C. "Correlates of Adolescent Suicide Attempts: Alienation, Drugs and Social Background." *Journal of Alcohol and Drug Education*, 34(3) (1989):85-96.

Anonymous self-report methods with 2,690 adolescents ages 12 to 18 in Genesee County, Michigan were used in this study to determine the relationship of drug and alcohol use and demographic factors to suicide attempts.

The study confirmed the greater attempt rate by females and found a ratio of 2.11 suicide attempts by females for each male attempt. It was found that nonwhites show a greater rate of suicide attempt (11.56%) than whites (7.12%) and that cities have higher than average teen suicide attempt rates (8.50% vs. an average of 7.68%). The study reveals that rural areas are where young people are at greatest risk for suicide attempt with 16.22% of young people reporting a suicide attempt.

Questions on alienation revealed that those students who indicated feelings of alienation (including being dissatisfied with life, being unhappy, not liking school, and feeling extreme pessimism about the future) were much more likely to have been suicide attempters.

The relationship between drug use and suicide attempts was examined and revealed that drugs such as LSD, cocaine, amphetamines, barbiturates, and tranquilizers appear to be much more important in predicting suicide attempts than alcohol and marijuana. However, gender-specific findings in substance use and suicide attempts were that female frequent drinkers or heavy marijuana users are more likely to report suicide attempts than female infrequent or moderate users or male users of those substances.

Keywords: Alienation
Drugs (cocaine, LSD, amphetamines, etc.)
Gender differences
Rural/urban aspects

12. Kirkpatrick-Smith, J., Rich, A.R., Bonner, R., and Jans, F. "Psychological Vulnerability and Substance Abuse as Predictors of Suicide Ideation Among Adolescents." *OMEGA*, 24 (1991):21-33.

An accepted model of suicidal behavior places this behavior along a continuum from suicidal ideation, through more serious suicidal behavior, contemplations, threats, attempts, and completions. According to this model, ideation is believed to precede and perhaps lead to contemplation of suicide and contemplation to threats, and so on. By understanding what leads to suicide ideation, greater understanding of the causes of completed suicide can result.

This study sought to test the influences of life stresses, hopelessness, reasons for living, loneliness, depression and alcohol and drug use on suicidal ideation among high school students. A questionnaire addressing these issues was administered to 790 eighth through twelfth graders in an upper middle-class, suburban school district in western Pennsylvania.

Results of the study indicated that 46% of the students reported no current suicide ideation, 40% reported occasional thoughts of suicide, 10% reported intermittent thoughts, and 4% reported persistent thoughts of suicide. Responses to the drug and alcohol survey indicated that 72% of the students drink alcohol. Most of the students began drinking in junior high school (43%), 23% started drinking in senior high school, and 10% began drinking in elementary school Five percent of the students believed they had a problem with drugs, and 12% think that at least one of their parents has an alcohol problem.

The variables that were found to be significant predictors of suicide ideation among students were hopelessness, depression, having few reasons for living, and substance abuse. Furthermore, substance abuse was found to make an independent contribution as a predictor of suicide ideation while also being significantly related to depression, hopelessness, and reasons for living.

Life stress was not highly correlated with suicide ideation in this sample, nor was loneliness, but loneliness was significantly related to depression and hopelessness which were linked to suicide ideation.

Implications for prevention efforts include maintaining emphasis on reducing alcohol and other drug abuse, introducing curriculum to help students improve problem-solving skills, and increasing awareness and knowledge of risk factors related to suicide to assist school personnel in identifying at-risk youth.

Keywords: Depression
Family aspects
Prevention strategies
Stress

13. Manson, S.M., Beals, J., Dick, R.W., and Duclos, C. "Risk Factors for Suicide Among Indian Adolescents at a Boarding School." *Public Health Reports,* 104 (1989):609-614.

Noting the suicide rates among Native American adolescents which are 2.4-2.8 times higher than those for the general population of adolescents, a sample of 190 high school students attending an Indian boarding school were surveyed to measure the prevalence and incidence of the suicide risk factors of depression, anxiety and substance abuse. Also examined were stressful life events, coping strategies, social support, competence, and self-esteem.

Results of the survey indicate that 23.4% of the students reported having attempted suicide at some time. During the past month, 20.9% had thought about suicide, 9.6% would have liked to kill themselves, and 2.8% would have killed themselves if they had the chance. No age or gender differences were found. A strong relationship was found between relatives or friends having committed suicide and the students' attempts or current risk of suicide. Furthermore, high peer support was related to greater suicide risk, a troubling factor because of the students' reliance on their peers for support rather than on adult family members. Both of these results point to an imitative mechanism in suicidal attempt and ideation. Also showing a strong relationship to past suicide attempts and current risk for suicide were symptoms of depression. Greater consumption of alcohol was positively correlated to attempted suicide but not to current risk. Lack of support from family was correlated with attempted suicide, and the number of stressful life events experienced by the student was marginally related to previous attempts and current risk for suicide.

Prevention efforts in American Indian and Alaska Native communities emphasize early identification of adolescents' mental health problems and focus on substance abuse as a primary risk factor for suicidal behavior. Other prevention strategies could be developed around the other risk factors suggested by this survey: lack of familial support and the apparent imitative mechanism of adolescent suicide.

Keywords: Depression
Drugs (alcohol)
Ethnicity (Native Americans)
Family aspects
Prevention strategies
Stress

14. McKenry, P.C., Tishler, C.L., and Kelley, C. "The Role of Drugs in Adolescent Suicide Attempts." *Suicide and Life-Threatening Behavior*, 13(3) (1983):166-175.

There has been a marked increased in stress that adolescents in our society experience today compared to previous eras. These societal changes magnify the changes and disruptions characteristic of adolescence itself, and that an increasing number of young people are turning to self-destructive behaviors such as suicide and drug abuse to cope with these multiple stresses. Several theories as to why teens turn to drugs are proposed. One theory is that alcohol and other drugs temporarily reduce fear and anxiety. Another is that we have become a culture in which problems are regulated through the use of drugs and teens perceive that they have many problems and so have been conditioned to turn to drugs. The study looks at drug histories of 46 adolescent suicide attempters and their parents. These attempters and their parents are compared with a group of nonattempters and their parents on selected measures of drug use.

Findings indicate that drugs were used in the suicide attempt by 39 out of 46 of the young people (with one-third of these attempters using drugs in their attempts that belonged to their mothers or fathers) and that suicidal adolescents in general used significantly more drugs than the nonsuicidal group. Among the conclusions were that adolescent drug use is closely related to and perhaps symptomatic of suicidal behaviors and overall pathology. Forty-three percent of the adolescent attempters were found to have serious drug problems. There appeared to be a connection between parental substance abuse and teen suicide. It was found that both parents of the suicide attempters used significantly more alcohol than the parents of nonattempters, but the parents of the attempters felt their use of alcohol and other substances was well within the moderate range. Meanwhile, 24% of the teenage suicide attempters reported that at least one parent had a serious drug or alcohol problem.

Implications for those who work with suicidal adolescents and their families include viewing adolescent drug use as one form of self-destructive behavior that can be related to suicide. Moreover, parental substance use can be considered "not only as indicative of some degree of family pathology, but also as modeling self-destructive coping patterns instead of such healthy behaviors as conflict resolution, independence, and assertiveness. Thus, parental drug abuse can indicate an adolescent's potential for self-destructive behavior." Also noted among adolescent suicide attempters and their families were indications of greater psychological distress, including depression, anxiety, suicidal ideation, and lower self-esteem, than among the nonsuicidal teens and their families.

It is suggested that the coping skills suicide-attempting teens learned from their parents were not as effective as those which nonattempting teens learned from their parents.

Keywords: Depression
Drugs (alcohol)
Family aspects
Stress

15. Murphy, G.E "Suicide and Substance Abuse." *Archives of General Psychiatry*, 45 (1988):593-594.

The results from several research studies on suicide and substance abuse indicate that a recent loss or a disruption in an interpersonal relationship is a predictor of suicide among substance abusers more so than among people with other psychiatric disorders . It is noted that there has been a "stunning growth of the problem of substance abuse in recent years" and that a recent study reflected a diagnosis of substance abuse in 58% of suicide cases compared to a range of 15% to 39% of suicide cases in earlier studies.

The findings indicate the increasing prevalence of the overlapping of substance abuse and alcohol abuse. In the San Diego suicide study cited in this report, 84% of substance abusers abused both alcohol and other drugs. A highly significant difference discovered between younger and older suicides is that 67% of suicides under age 30 were determined to be substance abusers compared to 46% of those over 30.

Implications drawn from this study show that attention should be paid to developing the substance abuser's social support system and that suicidal thoughts must be inquired about and taken seriously.

Keywords: Interpersonal factors

16. Rogers, J.R. "Suicide and Alcohol: Conceptualizing the Relationship From a Cognitive-Social Paradigm." *Journal of Counseling & Development*, 70 (1992):540-543.

Many studies have linked alcohol use and suicide, but no theories have been presented to explain the nature of the association. The author reviews the literature on the nature of the alcohol/suicide connection and then presents a new theory for the nature of their connection.

The most common hypothesis for the link between alcohol and suicide is primarily pharmacological. This theory suggests that alcohol exacerbates psychiatric or interpersonal risk factors for suicide such as depression, social isolation, or social stress. However, most of the evidence for the pharmacological theory has been derived from data on alcoholics even though more moderate alcohol use has also been shown to be related to increased risk for suicidal behavior.

A new paradigm for conceptualizing the association between alcohol and suicidal behavior is offered. This new theory links recent theories on alcohol's effects on general social behaviors to the research on suicide. Recent research on the effects of alcohol illustrates that a cognitive effect of alcohol consumption is alcohol-induced myopia (narrow view). This alcohol myopia is defined as "a reduction in the range of perception and ability to engage in inferential thought," which, in effect, traps the drinker in a cognitive state in which envisioning a full range of options is impossible. This myopic effect was observed, though to a reduced degree, even with moderate intake of alcohol. Alcohol myopia maybe why alcohol intake can reduce psychological stress, such as depression and anxiety, when it is accompanied by a distracting activity; the alcohol inhibits the anxious or depressed drinker from thinking about anything other than the distracting activity. Alcohol myopia was also suggested as an explanation for why alcohol intake increases psychological stress when it is not accompanied by a distracting activity; it reduces the range of thought to only those of the drinker's troubles, inhibits problem-solving ability, and can thus limit hopes for the future.

Alcohol myopia mirrors the cognitive and perceptual constriction found in suicide by another researcher. Without reference to alcohol, this researcher identifies one of 10 commonalities of suicidal behavior as extreme affective and intellectual constriction. According to this researcher, it appears to suicidal individuals that their range of options is very narrow, so narrow, even, that they see only two choices: "either some total solution or cessation."

The new paradigm offered by the author consists of placing these two phenomena together to explain the relationship between alcohol and suicide. It is suggested that these two constrictive tendencies feed one another in the alcohol-using suicidal individual. If a person is experiencing the preexisting constrictive state of suicidal behavior, alcohol use would contribute further cognitive and perceptual constraint.

An implication for intervention is to consider alcohol use a "moderator variable in suicidal behavior," and thus "an appropriate target for intervention efforts." Counselors are urged to investigate clients' alcohol use patterns in evaluations for suicidal risk and to investigate alcohol-using clients' previous suicidal behavior.

Keywords: Drugs (alcohol)
Intervention strategies

17. Schiff, M.M., and Cavaiola, A.A. "Teenage Chemical Dependence and the Prevalence of Psychiatric Disorders: Issues for Prevention." *Journal of Adolescent Chemical Dependency*, 1(2) (1990):35-46.

Data were collected on 50 randomly selected chemically dependent adolescent patients at a six week residential nonhospital program. The data were compared to a second group of 50 nonchemically dependent adolescents. Findings indicate that the chemically dependent youth started using substances at a younger age (around twelve years old) compared to the control group (around fourteen years old). In addition, the chemically dependent group was significantly more likely to have legal problems (70% vs. 10%), prior substance use treatment and out-of-home placements (70% vs. 8%), and sexual acting out including prostitution, venereal disease and indiscriminate sex (48% vs. 14%). They were also more likely to have experienced physical and sexual abuse (40% vs. 6%) and to have been given special education classifications in school (34% vs. 6%).

Chemically dependent adolescents made more suicide attempts (26% vs. 4%); however, suicide ideation without attempt or gesture was more common in the teens who were not chemically dependent. This could suggest that chemically dependent youth are more likely to act on suicidal thoughts.

The parents of the chemically dependent adolescents differed in several ways from the parents of the nonchemically dependent youth. They were more often divorced (56% vs. 26%), chemically dependent themselves (68% vs. 12%), or had a history of psychiatric problems (20% vs. 4%).

The authors conclude that prevention strategies be placed into the categories of primary prevention topics and secondary prevention topics. Primary prevention topics include preventing chemical dependence in the next generation by providing alcohol and other drug education to students in the early elementary grades, more aggressively educating teens about the dangers of driving or engaging in sex while under the influence of alcohol and other drugs, screening pregnant teens and adults to prevent fetal alcohol and drug related syndromes, and making early identification for newborns of family histories of substance abuse, learning problems, and affective disorders. Secondary prevention topics include treating addictive and psychiatric problems concurrently and providing for early identification and treatment of high risk factors for substance abuse before substance abuse occurs. Some of those high risk factors are attention deficit disorder, affective disorders, and abuse.

Keywords: Family aspects
Prevention strategies
Treatment strategies

18. Schuckit, M.A., and Schuckit, J.J. "Substance Use and Abuse: A Risk Factor in Youth Suicide." In *Report of the Secretary's Task Force on Youth Suicide, Volume 2: Risk Factors for Youth Suicide*, Alcohol, Drug Abuse and Mental Health Administration, U.S. Department of Health and Human Services, DHHS Publication No. (ADM) 89-1622 Washington, D.C.: U.S. Government Printing Office (1989).

The literature on the relationship between suicide and the use and abuse of substances in youth to age 24 is reviewed. Both the direct and indirect associations between substance use and misuse and suicide among adolescents are discussed, and the high suicide rate among substance abusers is noted. One of the direct associations between substance use and suicide is the use of drugs or alcohol as part of the suicidal act. Drug overdose is a favorite means of suicide or suicide attempt, with studies indicating that between 78 and 100 percent of reported attempted youth suicides used drug overdose. Also among the direct associations is the evidence indicating that intoxication with drugs or alcohol frequently takes place immediately prior to a suicide attempt, probably impairing judgment, heightening impulsiveness, and exaggerating mood swings. Furthermore, substance abusers report suicidal activity. One study showed that at least 20% of alcoholics report histories of suicide attempts. Among drug abusers, at least 15% reported such histories. The lifetime rates of suicide completion among alcoholics and drug abusers have been estimated at 15% and 10% respectively. Studies of completed suicides indicate that 15-50% have a history of alcohol abuse and 20-50% have a history of drug abuse.

In citing the indirect connections between substance use or misuse and suicidal behavior, the authors note several psychiatric disorders in which both behaviors are common problems including antisocial personality disorder, borderline personality, affective or depressive disorders, and schizophrenia. Substance abuse appears at a rate higher than in the general population among patients with these disorders, and substance abuse can exacerbate the symptoms of depression, psychotic thinking, or intensify mood swings and therefore could increase suicidal behavior. Also among the frequently observed indirect connections are family instability (including substance abuse by parents) and a high rate of psychiatrically ill relatives among suicidal young people.

Findings indicate that collection and analysis of data on the connections between suicide and substance use need to be continued and physicians need to take care in prescribing drugs of potential abuse to emotionally disturbed adolescents. Educating parents and adolescents on the importance of refraining from alcohol and other drug consumption during times of stress is also recommended.

Keywords: Family aspects
Psychiatric disorders

19. Shaffer, D. "The Epidemiology of Teen Suicide: An Examination of Risk Factors." *Journal of Clinical Psychiatry*, 49(9) (1988):36-41.

Included in this article is a general systematic overview of empirical data on the incidence of teen suicide in the United States and in other countries. Secular trends in suicide incidence are presented, and it is shown how these have varied a great deal for different age and cultural groups. Adolescent suicide is increasing at a faster rate than suicide among the elderly or middle aged and has increased most rapidly among white males between 15 and 24 years old. Whites kill themselves at higher rates than blacks, and some Native American groups have the highest rates, sometimes as much as twenty times the national average. Some theories proposed to explain these differences include the possibilities that suicide is underreported among some ethnic groups, that apparent differences among suicide rates for different ethnicities may really be social class differences, that there could be cultural differences that promote or inhibit suicide (such as the acceptability of certain suicide rituals or a tradition of very strong taboos .) The author notes that these ethnic differences need further study.

Adolescent boys commit suicide at about five times the rate for adolescent girls with firearms being the most common method used. A geographical difference is that youth in the western United States, including Alaska, commit suicide at the highest rate. Some theories to explain this are possible greater availability of firearms and the ethnic mix in this region.

The phenomenon of cluster suicide is discussed, especially in terms of media treatment of suicide. One study cited showed that prominent news coverage of a suicide leads to a predictable increase in suicidal death, especially among young people, in the one to two weeks following the coverage. Another study showed that suicide attempts and completions increased after fictional television programs featured suicide. The nature of the apparent imitative process observed in some suicidal behavior is not fully understood.

The advantages and limitations of the various methods employed to study suicide, including death certificate data and psychological autopsy, are outlined. Preliminary results from a current psychological autopsy study on consecutive adolescent suicides in the New York Metropolitan area are presented. These results show that many teens commit suicide in the midst of a "disciplinary crisis" or after a rejection or humiliation, such as breaking up with a boyfriend or girlfriend. There is evidence that the victims were experiencing extreme fear, anger, or had been drinking heavily. Approximately one-half of all the victims had had previous contact with a therapist with symptoms of depression, antisocial behavior, drug and alcohol abuse, and learning disorders. Victims also had a high proportion of relatives who had attempted or committed suicide.

Keywords: Cluster effect
Ethnicity
Family aspects
Firearms
Gender differences

Suicide Prevention, Intervention, and Postvention In the Schools

20. Allberg, W.R., and Chu, L. "Understanding Adolescent Suicide: Correlates in a Developmental Perspective." *School Counselor*, 37 (1990):343-350.

The authors identify correlates of teenage suicide and explains their interactions in a cognitive developmental perspective to help counselors of adolescents. Understanding that adolescent suicide results from the interaction of various factors prevents counselors from looking for a single life stressor that is prompting suicidal behavior and helps the counselor devise effective ideas for prevention and treatment.

The first key symptom of suicide is depression which has been noted in one study as occurring in three out of four adolescent suicide victims. Counselors, therefore, must know the symptoms of depression, including social withdrawal, complaints of boredom, impairment in school work, pathological guilt, fatigue, lack of spontaneity, incapacity for experiencing pleasure (anhedonia), and a mood change lasting one month or more. All depressed youth should be assessed for suicidal ideation. It was found that some children do not exhibit the overt symptoms of depression but may display masked depression, which in one study was found in 50% of young suicide attempters. Some symptoms of masked depression include sexual promiscuity, delinquency, or drug use or physical problems such as anorexia, colitis, or psychosomatic illnesses. One cited study determined that the habitual abuse of alcohol and other drugs (noted in 50% to 70% of adolescent suicide attempters) "was frequently an attempt to self-medicate against severe depression."

The next correlates in adolescent suicide is isolation and impaired interpersonal contacts. Given the greater frequency with which adolescents face interpersonal conflicts than do those older or younger in the population, isolated teens have few other relationships to serve as support during the conflict. Without mature coping skills, the loss of a relationship, such as the death or divorce of parents, breakup with a boyfriend or conflicts with friends push isolated teens toward the perceived solution of suicide.

Another correlate in adolescent suicide is family conflict, such as disorganized family structure or lack of productive communication, impaired problem-solving ability or the divorce or separation of the parents or the death of either or both of the parents.

A final correlate in adolescent suicide is the presence of an emotional disorder. One study noted that certain character and personality disorders, especially impulsive character disorders, are present in suicidal adolescents. The tendency toward major depression is also reported as a common characteristic of suicidal teens.

These correlates are placed in the framework of the developmental perspective of adolescence, recognizing adolescents' natural urge to define themselves and thus come into conflict with adults, their sometimes inadequate communication skills and coping patterns which can exacerbate their problems, their tendency toward egocentrism, and their lack of perception of the finality of death. Their egocentrism, particularly, can cause

suicide to seem an acceptable solution as they fantasize their death as a statement, a way of creating an effect on others, rather than a final irrevocable act.

Understanding the multiple correlates and the developmental perspective of adolescent suicidal behavior helps the counselor determine areas in which effective interventions could be implemented, for instance in communication and interpersonal skills development to address interpersonal conflicts or offer opportunities for parents to enhance their parenting skills. Understanding the correlates of teenage suicide helps the counselor see the limits of the school counselor role and prompts the counselor to develop a referral network for teens experiencing suicidal ideation or any of the correlates of suicidal behavior.

Keywords: Counseling
Depression
Family aspects
Identification
Interpersonal factors

21. Barish, S. "Responding to Adolescent Suicide: A Multi-Faceted Plan." *NASSP Bulletin*, 75(538) (1991):98-103.

Using first-hand experience of a suicide by a high school student, a principal reviews components of a "suicide postvention plan," that is, a plan of action designed to help the school respond after the suicide of a student.

The first steps of the plan include verifying information about the suicide and enlisting community support by immediately contacting police, the superintendent, the president of the PTA, local clergy, and community agencies that deal with adolescent depression and suicide.

The next step is to relay the facts to the school community; the suicide must not be ignored. In his school, the principal had all homeroom teachers read the same prepared announcement to their homeroom classes on the morning of the school day following the suicide. This prepared announcement ensured that all students received the same message about the suicide. The message stated that a student had committed suicide, that the reasons for the suicide were not clear to the school or the family, and that those who wanted to discuss their feelings about the death should contact the guidance resource center, their counselor, one of the psychologists, or the social worker. In addition, the principal had prepared for the staff a fact sheet outlining the plans for the day, including advising staff to refer to a counselor any friends of the victim and any students who appeared depressed.

The principal stresses that in relaying the facts as well as in management decisions regarding the suicide in the days following the incident, the suicide must not be glorified as that can lead to copy-cat suicides. In particular, symbolic gestures, such as flying the flag at half-mast, symbolic of the death of a hero, should be avoided. Another area of concern for the principal is the news media, including the student newspaper which may be prone to sensationalizing the suicide. In this particular case, the suicide victim had stated in his suicide note that he wanted it to be published in the student newspaper. The principal intervened with the newspaper editor to prevent publication of the letter as it could risk harm to vulnerable students. In the case of the community media, the staff was alerted to give no comment to any reporters who might visit the school and to refer them immediately to the principal.

Several weeks following the suicide, noting that many vulnerable students still needed support, the principal arranged for an evening program on adolescent depression and suicide prevention. The program, for adults only, was cosponsored by parent and community groups, featured a renowned speaker on adolescent depression, was heavily publicized in advance, and was well attended and informative.

Further efforts to prevent any other suicides included meeting with community mental health providers, some of whom volunteered to assist with school based planning to address adolescent depression.

In reflecting on how the plan worked, the principal notes that students appreciated that the message of the suicide was delivered to them personally. When the students received open communication and things were explained to them, they handled the tragedy capably and sensitively.

Keywords: Community involvement
Depression
School programs
Postvention

22. Berkovitz, I.H. ""Building a Suicide Prevention Climate in Schools. In S.C. Feinstein (Ed.), *Adolescent Psychiatry: Developmental and Clinical Studies, Volume 14*, (pp. 500-510). Chicago: University of Chicago Press (1987).

While many causes of adolescent suicide come from sources outside of school, school problems have contributed to suicide and attempted suicide among some adolescents, and emotionally vulnerable young people can be strongly influenced by events at school and relationships with school adults and peers. Studies indicate that youth who attempt suicide often have poor academic records, may be upset at their inability to meet the standards of academic work they have set for themselves, be dropouts or truants, socially isolated, or have had a large number of school behavior or discipline problems.

In order to address these school-based factors which place students at-risk for suicide and to address suicide prevention in general, it is suggested that schools develop a "suicide prevention climate." The primary components of this suicide prevention climate are a positive mental health atmosphere, and optimum psychological services staff and organization. Other programs that can support a suicide prevention climate are a focused suicide prevention program and a suicide postvention program. The first two components are necessary for the other programs to be implemented successfully.

A positive mental health atmosphere entails that a school provide an overall environment that is supportive, humane, and challenging for young people and which gives them a sense of self-esteem. The principal and other administrators are responsible for this atmosphere and may enhance it through a positive administrative style that is neither intrusive nor judgmental to students or staff. The principal should provide inservice and training to staff so that they may become more sensitive to levels of depression, loneliness, apathy, and anxiety in their students. Furthermore, teachers need to be aware of and respond to "the nonverbal cry for help" and demonstrate that they are interested in and concerned about each student's emotional well-being. A strategy that could facilitate this is dividing large schools into smaller school units.

The second component of a suicide prevention climate is school psychological services. Ways that schools can optimize their psychological services are described, as guidance counselors, school psychologists, and nurses are often constrained by heavy work loads. It is suggested that schools identify and effectively utilize every counseling-oriented teacher and staff member, including custodians, cafeteria workers, secretarial staff, and security personnel. In addition, mental health resources in the community should be identified and utilized for staff training. Some successful programs are described, including one in which teachers and psychology trainees from a community health center led discussion groups of students identified as being socially isolated in the school. In another school, a school social worker arranged for social work students to lead counseling groups of high school students.

Suicide prevention and intervention programs, and a postvention plan may be used in some schools, but they will not function well without a positive mental health atmosphere and an adequate psychological services staff and organization.

Keywords: Community programs
Postvention
Prevention strategies
School climate
School programs

23. Ciffone, J. "Suicide Prevention: A Classroom Presentation to Adolescents." *Social Work*, 38 (1993):197-203.

Growing concern about adolescent suicide has prompted schools to institute suicide prevention programs. However, few of these programs have been scientifically evaluated so it is possible that well-intentioned but ill-conceived prevention programs might actually facilitate suicide and suicidal behaviors. The author uses an attitudinal survey to evaluate the effectiveness of his own suicide prevention program.

The program evaluated presents warning signs of adolescent suicide and basic intervention strategies. It emphasizes suicide as "a manipulative and unheroic act of poor judgment," and that suicide is an indication of mental illness. The program covers the differences between normal and abnormal adolescent feelings and stresses, positive strategies for coping with loneliness, rejection, and other losses.

The program was evaluated by testing to what degree it causes students to switch from undesirable attitudes to desirable ones. Prior to the program, a large number of students surveyed were found to hold undesirable or inaccurate views of suicide: 74% did not believe that teenagers who kill themselves are usually mentally ill; 55% would not seek out help for themselves if they felt very upset; 53% would not encourage a suicidal friend to obtain help from a mental health professional; 44% would ignore or joke about a peer who threatens suicide; and 43% would counsel a suicidal friend without obtaining help from someone else. Three other questions indicated that most of the students already held accurate or appropriate views: 67% said that if suicidal thoughts crossed their minds; they would seek out and talk to a friend about those thoughts; 83% felt suicide was not a possible solution for people who have a lot of problems; and 75% would not keep secret the suicidal feelings of a friend, even if the friend asked them to.

Exposure to the suicide program was found to have an overall positive effect on those teens who hold undesirable attitudes towards suicide. Significant effects were found in several areas. The program significantly influenced those adolescents who would otherwise counsel a suicidal friend without obtaining help. It increased the number of teens who would refuse to keep secret a friend's suicidal confidences and increased the willingness to refer a friend to a mental health professional It appears that the program did not change the minds of half of those students who originally felt that suicide is a possible option for people with a lot of problems.

Some conclusions from this study are that the mental health model of suicide presented in this program, does not appear to decrease students' willingness to refer themselves or their peers for assistance. The program may increase their willingness to view suicidal thoughts as abnormal and thus see the need for professional attention. It is suggested that the mental health model is more appropriate for students than the stress model which presents suicidal thoughts as a result of the normal stresses adolescents face. Thus, normalizing suicide can decrease referrals. This study found a large number of preprogram undesirable attitudes. This prevalence of undesirable attitudes suggests that suicide prevention

programs should be addressed to all students, not just those who appear to be at risk for suicidal behavior.

Keywords: Identification
Intervention
Program evaluation
School programs

24. Dunne-Maxim, K. "Can a Suicide Prevention Curriculum Harm Students' Health?" *School Administrator*, 48(5) (1991):25.

Citing the results of the Shaffer, Vieland, et al study ("Adolescent Suicide Attempters: Response to Suicide-Prevention Programs") which indicate that the suicide prevention programs studied did not change the beliefs or attitudes towards suicide of students with histories of suicide attempt, it is suggested that school administrators "approach suicide prevention cautiously." To date there is no definitive data on the effectiveness of suicide prevention curricula, but it is recognized that adolescents do need information on suicide, including how to get help.

Avoiding sensationalism in presenting adolescent suicide issues is advocated. Other components to be incorporated in a suicide prevention program include educating students about a variety of mental health problems such as parent alcoholism, and teaching them about how to identify common mental health symptoms such as depression and drug and alcohol dependency. School staff also need to be educated on the warning signs for suicidal behavior.

Keywords: Prevention programs
Program evaluation

25. Friedo, D.A. "How to Fight Teenage Suicide: A Parents' Guide to the Danger Signals." A press release of the University of Michigan Medical Center Health News Service, Ann Arbor, MI. (1986). (ERIC Document Reproduction Service No. 271 661).

Physicians have developed and tested a profile to be used by parents and professionals to help identify potential teenage suicide victims. The profile was developed using a study of 27 male and 37 female teenagers hospitalized in the Children's Psychiatric Hospital at the University of Michigan Medical Center. Adolescents were shown to be reliable reporters of information used to determine suicide potential. Possible indicators of potential suicide include talk of harming oneself, depressed mood, lack of a sense of pleasure, social withdrawal, decreased school performance, and a noticeable increase in substance abuse. Depression and drug or alcohol abuse was a particularly dangerous combination.

Two types of suicidal teenagers emerge from the profile. The first is a teenager who seems to be doing well with friends, school, and other aspects of life. However, at some point, a marked behavior change occurs in which the adolescent's school performance falls and hygiene diminishes. The teen may withdraw socially, have problems sleeping, and begin to lose weight This type of adolescent may have a chemical imbalance which predisposes them to suicide.

The second type of suicidal teenager has not done well in school, may have a learning disability, and exists on the fringe of social activities. This student begins to see himself as others do, as a loser.

Keywords: Identification

26. Garfinkel, B.D. "School-Based Prevention Programs." In *Report of the Secretary's Task Force on Youth Suicide, Volume 3: Prevention and Interventions in Youth Suicide*. Alcohol, Drug Abuse and Mental Health Administration, Public Health Service, DHHS Publication Number (ADM) 89-1623 Washington, D.C.: U.S. Government Printing Office (1989).

There are many suicide prevention programs that have been developed for junior and senior high schools with a focus of preventing suicide among the entire student population. Some of the programs have "serious omissions" of one or more of the nine aspects which the author deems necessary in a school-based suicide prevention program. Those nine essential components and their key components are outlined below.

The first component is early identification and screening of students at risk for suicidal behavior. It is suggested that school personnel keep a registry of students at potential risk for suicide. The criteria upon which students may be identified and screened include the general areas of depression, psychosocial stressors affecting students, and the methods students use to respond to and handle difficult problems. Some specific risk factors to watch for are: the student being an older male adolescent; having made previous suicide attempts, experiencing chemical dependency in the family; exhibiting a deteriorating school performance; and having a prior history of depression. Students who experience stressful life events should also be identified. Stressors which place students at risk for suicide include breaking up with a boyfriend or girlfriend, having trouble with a sibling, parents or teacher, changing to a new school, experiencing a change in parents' financial status, having the parents divorce, losing a close friend, and experiencing personal injury or illness. Certain behavioral patterns also characterize young suicide attempters, including angry and explosive outbursts, passive withdrawal into drinking, smoking, and drug usage, avoidant behaviors such as hypersomnia, joyriding and infrequent communication with adults, and antisocial behaviors such as fighting, stealing, and vandalism.

The second essential component of an effective school-based suicide prevention program is a comprehensive and thorough evaluation of the depressed, suicidal, and psychiatrically disturbed young person by means of using structured systematic psychiatric diagnostic interviews such as the Kiddie-Schedule for Affective Disorders and Schizophrenia (K-SADS), the Diagnostic Interview for Children and Adolescents (DICA), (individual and parent), or the Diagnostic Interview Schedule for Children (DISC), (individual and parent). In addition to depression, hopelessness and suicidal intent should also be measured. In students who have made a suicide attempt, the seriousness of the attempt needs to be evaluated.

The third component is crisis intervention and case management with students identified as suicidal or who have made a suicide attempt. This process should consist of "brief, collaborative problem-solving therapy emphasizing the rapid resumption of control over one's environmental future." It should employ crisis intervention teams composed of members from within the school and from the community. Possible members of or

consultants to the crisis intervention team could include a child and adolescent psychiatrist, school psychologist, nurse, social worker, teacher, principal, speech pathologist, occupational therapist, coach, audiologist, pediatric neurologist and clergy. The purpose of the crisis intervention team is to transform, for the depressed and suicidal adolescent, an environment that had precipitated the crisis. The team's goal is to provide a "supportive, concerned, and empathetic group of individuals prepared to work with the individual to alleviate psychological and social stress."

The team ensures that the suicidal teen receives the necessary assessment, psychotherapy and social work following a suicide attempt. This process should include evaluating the degree of hopelessness, suicidal risk, and danger of the student's actions, having the student list his or her existing problems and psychosocial stressors (possible precipitants to the suicidal behavior), identifying and addressing any psychiatric disorders (both affective and cognitive, such as depression, a learning disability or attention deficit disorder), investigating and addressing family psychopathology, especially alcoholism, family breakdown, and suicide attempts by family members, and exploring and enhancing the coping mechanisms of the youthful suicide attempter. Finally, the team should establish a contract with the student suicide attempter in which the student agrees not to attempt suicide for a specified period of time, sufficiently long to allow for mood elevation and the resolution of some of the stressors in the student's life.

The fourth component of effective school-based crisis programs is a crisis management program outlining what will take place in the school immediately following a suicide. Following a completed suicide, efforts should be directed toward survivors to prevent social modeling (imitation) from occurring and to prevent overwhelming feelings of guilt. When working with schoolmates of suicide completers, educators should listen to and discuss feelings of loss and abandonment resulting from the student's suicide. They should also stress the psychopathology and emotional and mental disturbance that the suicidal student was exhibiting so that the suicide is demystified and so that students are less likely to identify with the dead student. Memorializing of the deceased student should be minimized.

The fifth component of school-based suicide prevention is educational programs. The author reports that educational programs aimed at students or teachers whose purposes are to prevent teen suicide have not been demonstrated to do that; however, these programs thus far have also not been shown to have an enhancing effect on suicidal behavior. The results of a review of existing youth suicide prevention programs are reported. The review by the Greater Lakes Mental Health Foundation rated highest the curriculum developed by Thomas C. Barrett, Ed., entitled, "Youth in Crisis, Seeking Solutions to Self-Destructive Behavior." The author found a major flaw with this curriculum because it deemphasizes mental disorders as a cause of youth suicide. The guide of the Fairfax County, Virginia Public Schools, "A Guide to Adolescent Suicide Prevention Programs Within the School" gives what appears to be a more balanced view of depression and suicide.

Some education programs for students focus not on suicide, per se, but on effective adaptation, coping skills, communication, and early self-recognition of depression. One program that contains such a component is by the Suicide Prevention Center in Dayton, Ohio. The author suggests that examining ineffective coping styles and more effective coping mechanisms is undoubtedly very useful for students. A potentially worthwhile educational strategy is guiding students to "deemphasize passive withdrawal, avoidant types of behaviors, alcohol and drug usage, [and] angry and antisocial behaviors." It has not been shown whether suicide prevention educational programs enhance coping skills, communication, and reduce suicidal behavior or whether they inadvertently provide role models to depressed students and guide more people to attempt suicide.

The sixth component of a school-based suicide prevention program is monitoring and follow up on students identified as at risk or who have made a suicide attempt. Because of the extensive time students spend in school, school suicide prevention teams are in an ideal position to do this.

Seventh, suicide prevention teams in schools can serve as effective community linkages and networkers. Suggested links are with other school districts, high schools, community mental health centers, hospitals, universities, churches, private mental health practitioners, the legal system, including truant officers, probation officers, community police officers, and the media. The media link can help in ensuring deemphasized coverage of suicides. Overall, the goal of community networking is to exchange expertise on youth suicide among the groups and to serve as "a prevention, crisis intervention, and research base for the enhancement of scientific and clinical knowledge about youth suicide."

Eighth, schools can help the teen suicide prevention effort by participating in research on the epidemiology, causation, and longitudinal follow-up of attempters.

Finally, informed, active suicide prevention teams who network within the school, with parents and the community can be powerful advocates for students experiencing behavioral, physical, social and emotional problems. For example, depressed and suicidal students need advocates among teachers and parents who need to be aware that depressed and suicidal individuals may "lack the energy, social skills, and abilities to deal effectively with the usual adolescent developmental demands" and that punishing such students for incomplete homework or what seems like excessive daydreaming can be detrimental to the depressed student. It is suggested that the most helpful feature of the

advocacy role of suicide prevention teams in the schools is their ready availability to the suicidal student any time school is in session.

Keywords: Community programs
Depression
Identification
Intervention
Postvention
Prevention strategies
Program evaluation
School programs

27. Garland, A., Shaffer, D., and Whittle, B. "A National Survey of School-Based, Adolescent Suicide Prevention Programs." *Journal of the American Academy of Child and Adolescent Psychiatry*, 28(6) (1989):931-934.

A national survey of suicide prevention programs was conducted to determine the number, distribution, and content of school-based curriculum programs for adolescents. One hundred fifteen programs were identified. The total number of students and schools targeted for prevention efforts more than doubled during the academic years 1984-1985 to 1986-1987.

Content of the programs was similar, with nearly all including information on suicide warning signs and other facts, as well as on accessing community mental health resources. All programs adopted a universal strategy; they were aimed at all adolescents regardless of their individual vulnerability to suicide. Most included a separate component for school staff and parents. The design of the programs assume that suicidal teens would be most likely to talk to their friends when in distress or need of support. Ninety-five percent of the programs subscribed to the view that suicide is most commonly a response to extreme stress or pressure and could happen to anyone rather than emphasizing a view that suicide is linked to mental illness. This view couteracts prior research that has shown that suicide is usually a consequence of mental illness. A possible negative implication of this stress model of suicide is if suicide is presented as something that could happen to anyone, the likelihood for imitation of suicidal behavior could increase.

The value of prevention programs aimed at all students is questioned when suicide is a rare occurrence (approximately 10 suicides per 100,000 teens) and when suicide prevention programs presently reach only about one percent of all 15- to 19-year olds.

Education and training in suicide prevention for adults is endorsed, particularly for teachers and parents. While this survey represents an important first step in providing a description of these programs, more evaluative research is needed to determine what effect, if any, these programs have on suicidal behavior.

Keywords: Program evaluation
School programs

28. Garland, A.F., and Zigler E. "Adolescent Suicide Prevention: Current Research and Social Policy Implications." *American Psychologist*, 48(2) (1993):169-182.

The rate of adolescent suicide has increased dramatically in the past few decades, prompting several interventions to curb the increase. Unfortunately, many of the intervention efforts have not incorporated current research findings because the communication between researchers and those who develop the interventions is inadequate. Of specific concern are the increasingly popular curriculum-based suicide prevention programs, which have not demonstrated effectiveness and may contain potentially deleterious components. The authors review the current epidemiological research in adolescent suicide and suggest how this knowledge could be used more effectively to reduce the rate of adolescent suicide.

Current demographic aspects of adolescent suicide account for 11.3 deaths per 100,000 in the 15-19-year age group. Suicide rates among adolescents have risen by more than 200% since 1960, while those among the general population have risen by only 17%. The probable underreporting of suicide rates is also discussed.

Researchers have identified a number of risk factors of suicide, including substance abuse, prior suicide attempt, affective illness such as depression or manic depression, antisocial or aggressive behavior, family history of suicidal behavior, and the availability of a firearm.

The risk factor of psychiatric disorder is an important one. One study showed that 92.6% of a sample of 27 adolescent suicide completers were diagnosed with at least one psychiatric disorder. A study with a sample of 200 adolescent suicides indicated that about one half of the victims had some kind of mental illness. Another researcher concluded that only a small minority of adolescents who commit suicide have no discernible psychiatric symptoms.

Substance abuse is a significant risk factor for adolescent suicide. One study found that at least one-third of the teens who commit suicide are under the influence of alcohol at the time of death and many more may be under the influence of other drugs. Another study of adolescent suicides indicated that 10% of the victims were alcoholics and 12% were abusers of other drugs. Researchers have suggested that substance abuse may accompany so many suicides because it decreases the inhibitions to suicide.

Various suicide prevention efforts are reviewed including suicide prevention hotlines and curriculum-based programs. Suicide hotlines have been shown to be minimally effective in reducing suicidal behavior. They appear to slightly but significantly reduce suicide rates among white women only.

Some suicide prevention programs unwisely use print of visual media to present case histories of adolescents who attempt or commit suicide. These approaches may allow students to identify with the suicidal students and thus begin to see suicide as an appropriate solution to their own problems.

School-based suicide prevention programs are also criticized for the likelihood that they will for the most part miss their target audience--adolescents most at risk for suicide. Students who regularly attend school are not among those at highest risk for suicide. Youth who have run away, are in jail, or have dropped out of school are at extremely high risk for suicide. The authors recommend that "future suicide prevention efforts. . . be based on empirical data that can help to identify children who may be at risk for suicide so they can be referred to more therapeutic interventions."

Recommendations for social policy on adolescent suicide include creating a national resource center clearinghouse which would provide training and a national public awareness campaign. Another recommendation is to increase research on adolescent suicide. Lack of emphasis on research has been a problem in many teen suicide prevention efforts and has resulted in suicide prevention programs being mandated in several states without ever being properly evaluated.

Potentially more effective approaches to youth suicide prevention are:

1. Integrated primary prevention programs which address substance abuse, depression, lack of social support, poor problem-solving skills, and hopelessness. All of these variables are risk factors for suicide, but they are also risk factors for a range of other behaviors such as delinquency, dropping out of school, and teen pregnancy. Further components of such a program could be general mental education, health promotion, and encouraging help-seeking.
2. Family support intervention which help families improve their coping abilities.
3. Suicide prevention programs aimed at educators, health and mental health care workers.
4. Programs designed to identify and treat youth who are most at risk for suicide. In schools that have experienced a suicide, efforts to identify potentially suicidal students need to be made.
5. Hotline programs using referral to and followup by mental health providers. The effectiveness of hotlines could be increased with heavier advertising of the service to reach other populations besides those who most frequently use the hotlines, young white women.

Keywords: Drug abuse (alcohol)
Intervention strategies
Prevention strategies
Psychiatric disorders
School programs

29. Kalafat, J. "Adolescent Suicide and the Implications of School Response Programs." *School Counselor*, 37 (1990):359-369.

Suicide response programs should make use of the statistics on adolescent suicide as well as concepts from crisis intervention and adolescent development. Current statistics on the prevalence of adolescent suicide and suicide attempts and characteristics common among teenage suicide victims are reviewed. A table of suicide warning signs notes feelings, actions or events, changes, and threats on the part of students which should alert educators to take action.

Goals for school-based suicide prevention programs include providing "mental slowdowns" to combat the tunnel vision that causes teens to see suicide as the only way out of their problems. Adults who might come into contact with suicidal youths should know the warning signs and how to respond to them and have available professional mental health supports. Support should be provided for suicide attempters after an attempt and after a completed suicide, support should be given to those most affected by the loss of the suicide victim.

Concerns school personnel may have about introducing a suicide prevention program with students and thus, perhaps, introducing the idea of suicide to students who had not previously considered it, are addressed. It is argued that students need a balanced exposure to the topic which stresses coping, appropriate actions, and resources.

The role of the school in a suicide prevention program is in aiding identification of at-risk youth by educating students, staff, and teachers in the warning signs, providing support and response in referring an at-risk teen to obtain outside help, and in having in place a structured plan for coordinated response following a suicide or a serious attempt.

It is recommended that comprehensive suicide prevention programs should include administrative policies and procedures, informed faculty, staff, parents, and students, and effective community liaison. Further suggestions are provided on how to fit the program into the class schedule, grounding the program in the development of teens, providing an educational focus relevant to teens, avoiding clinical jargon, and having regular classroom teachers present the sessions to students.

Keywords: Identification
Intervention strategies
Postvention
Prevention strategies

30. Puskar, K., Lamb, J., and Norton, M. "Adolescent Mental Health: Collaboration Among Psychiatric Mental Health Nurses and School Nurses." *Journal of School Health*, 60(2) (1990):69-71.

Psychiatric mental health nurses are recommended as valuable resources for promoting mental health among adolescents. A possible area of involvement in schools is in assisting in programs to educate students, staff, and parents about adolescent stresses, communication skills, and useful coping strategies.

Selected school-based teen suicide prevention programs are reviewed. Using criteria for the basic elements of exemplary prevention programs, four programs were compared on content, format, theory, and focus of intervention. The first program was the Fairfax County (Virginia) Public Schools. This program provides for teacher training on suicide awareness, identifying potentially suicidal adolescents, and knowledge of community resources. Students participate in workshops and classroom sessions focusing on stressful life issues. Peer support and counseling groups are available to students.

Another program reviewed is the Adolescent Suicide Awareness Program (ASAP), developed by the South Bergen Mental Health Center and used by schools in Lyndhurst and Hackensack, New Jersey. This program is a combined effort of community mental health professionals and school personnel and provides staff, student, and parent components. It focuses on depression awareness, suicide warning signs, methods of helping the suicidal person, and community resources. Students attend workshops which address developing coping skills, managing stress, and peer counseling.

The Suicide Prevention Program of the Cherry Creek (Colorado) Schools is intended to identify students at risk for suicide. School personnel are trained to identify students at risk, students are taught a suicide prevention program and are provided with referral sources.

The San Mateo (California) Schools' prevention program was developed by the Suicide Prevention and Crisis Center of San Mateo County. The school makes resource persons available to students. School personnel are taught to identify adolescent depression and suicidal behavior. Students attend workshops and classroom presentations.

The four programs shared some criteria for excellent prevention programs, including lasting the entire school year and having a multilevel focus. All four of the programs were criticized for lacking information on theoretical background, methods of evaluation, cost-outcome benefits, ease of replication, and experimental design that "prevents assessment of specific advantages and disadvantages" of the different programs.

Keywords: Community programs
Program evaluation
School programs

31. Ryerson, D. "Suicide Awareness Education in Schools: The Development of a Core Program and Subsequent Modifications for Special Populations or Institutions." *Death Studies*, 14(4) (1990):371-390.

The Adolescent Suicide Awareness Program (ASAP) is outlined and a format for introducing it into schools is presented. The program is addressed to students, school staff, and parents, and it is designed to be implemented jointly by schools and mental health professionals in the community. Its goals are to educate every member of the school community about how to recognize and prevent teenage suicidal behavior and to establish and maintain communication and referral procedures with local mental health professionals. Secondary goals include creating attitudinal changes on the part of school communities, including "detoxifying" parental attitudes toward emotional difficulties, demonstrating that school personnel and therapists are caring, knowledgeable and approachable people, and promoting help-seeking behaviors. This last secondary goal is a key element of the program because teens, as well as educators and parents, need to be encouraged to overcome their natural reluctance to acknowledge that a young person is in trouble and then take action on that young person's behalf. The specific curricular means by which these goals are achieved are not described.

The procedures for implementing the program in schools and other human institutions are described. It is stressed that when schools or institutions request the program, local mental health providers should be trained to implement ASAP so that a link in the community referral network will be forged.

Modifications to the program are sometimes necessary because of special circumstances, such as whether a suicide recently took place in the school community, or the program may need to be tailored to the particular demographic makeup of the school.

Keywords: Community programs
School programs

32. Schmitt, R.L., and Ellman, T.D. (1991-92). Devaluating Death Education Through Short-Term Suicide Intervention Programs. *OMEGA: Journal of Death and Dying*, 24(3) 241-245.

The Shaffer, Vieland et al study ("Adolescent Suicide Attempters: Response to Suicide-Prevention Programs") and reactions to it are discussed and critiqued. Results of the study have suggested that suicide prevention programs in the schools are not helpful and are perhaps "dysfunctional," possibly upsetting students who are suicide attempters.

The authors of this article suggest that what should be questioned is not learning about suicide in the schools, but whether or not short-term suicide prevention programs, such as those examined by Shaffer, Vieland et al, have any place in the schools. It is argued that the programs studied by Shaffer, Vieland et al involved only one and one-half to three hours of instruction by classroom teachers who had received only six to ten hours of training. It is suggested that longer courses, such as full semester courses on death and dying which present suicide in the context of all death experiences and discuss the "complications of human interaction," could be more effective than the school programs studied.

Keywords: School programs

33. Seibel, M. and Murray J.N. "Early Prevention of Adolescent Suicide." *Educational Leadership*, 45 (1988):48-51.

Early warning signs among young children which point to possible suicidal behavior later in the teen years are described. Habitually dysfunctional coping patterns and a persistent pattern of failure and unhappiness in school are characteristics of children who may later attempt or complete suicide. It is suggested that by identifying these children in the early grades, the cycle leading toward suicidal coping patterns in the adolescent years can be disrupted.

Citing the success of early childhood teachers in identifying emotionally handicapped children, the authors call for these teachers to identify children with dysfunctional coping behaviors and that they, along with a team (composed of the principal, some teachers, and special services personnel such as the school psychologist, counselor, nurse, and social worker) review the cases of referred students, refer the students to in-school or outside counseling, and determine whether curriculum-based strategies for improving coping would be sufficient. The team would monitor results of the treatment, revise their referral and treatment strategies, and provide long-term followup.

Keywords: Identification
School programs

34. Shaffer, D., Garland, A., Gould, M., Fisher, P. et al. "Preventing Teenage Suicide: A Critical Review." *Journal of the American Academy of Child and Adolescent Psychiatry*, 27(6) (1988):675-687.

The risk factors for teenage suicide are reviewed, and preventive measures for these risk factors are discussed. The risk factors most associated with adolescent suicide are being male, depressed, and/or having made a previous suicide attempt. Therefore, the authors suggest that intervention efforts be directed toward teens who fit this profile.

Several strategies for prevention are introduced. Among those strategies is providing mental health services in the community, since most people who commit suicide have evidence of psychiatric illness at the time of death. Another strategy is restricting access to methods used to commit suicide. Given the high rate of suicide by firearm in the United States, especially by males who are substance abusers, denying ownership of firearms to households containing an alcohol- or substance-abusing member could reduce suicide completions.

School-based suicide prevention programs are discussed as a prevention measure, and their potential effectiveness is evaluated. The goals of school-based programs are to heighten awareness of the problem, promote identification of suicidal teens, provide information about mental health resources, and to improve teenagers' coping abilities. The programs aimed at the general population of students are considered a low risk strategy because "very few of the adolescents receiving the programs are likely to attempt or commit suicide."

Suicide hotlines are reviewed, and it is suggested that their effectiveness could be improved with better screening and training of hotline operators and active case management.

Research on clinical treatment procedures and postvention is also reviewed. Postvention (intervention with the community in which a suicide has taken place) attempts to provide a structure for understanding the death, minimizing the guilt and scapegoating that can affect the survivors, and reducing the likelihood of imitation. Few research studies are available on the effectiveness of postvention programs, and none are available on school postvention programs, leaving many questions in this area.

Keywords: Firearms
Prevention strategies
School programs

35. Shaffer, D., Vieland, V., Garland, A, Rojas, M., et al. "Adolescent Suicide Attempters: Response to Suicide-Prevention Programs." *JAMA: Journal of the American Medical Association*, 264(24) (1990):3151-3155.

As part of a controlled evaluation of three suicide-prevention curricula delivered to ninth- and tenth-grade students, 63 adolescents out of 973 were identified as having made a suicide attempt (6.5%). (The prevalence of suicide attempts as defined in this study by self-report was higher than that reported in studies using interview techniques (3-3.5%).) The attitudes about suicide and help seeking among the students who had attempted suicide were compared with those of the 910 nonattempters. Reaction to the prevention program was assessed by comparing the responses of the 35 attempters exposed to the programs with the responses of 524 exposed nonattempters. The impact of the programs was assessed by comparing 35 exposed attempters with 28 attempters from a control group.

Results indicated that prior to exposure to the programs, self-identified suicide attempters were less likely to endorse views consistent with the curricula. A significant difference found between attempters and nonattempters in beliefs and attitudes towards suicide before the programs was that attempters were more likely to feel that suicide is a possible solution for someone with problems (28.6% vs. 9.9% in the overall sample). Attempters also indicated that if a person is depressed, it is a good idea to keep those feelings to oneself (22.6% vs. 8.6%), and they also more often indicated that they had used a hotline or telephone crisis and counseling service. Furthermore, another significant difference found among the total group and among males was that attempters were also more likely to indicate that they drink alcohol or take other drugs when feeling very upset, sad, or unable to cope (9.5% vs. 2.4 % in the overall sample and 15.8% vs. 2.4% among males).

There was little evidence that the suicide prevention programs were successful in influencing these views. Attempters were significantly less likely than nonattempters to think that other students should participate in the same program (74.3% vs. 89.0% overall and 50.0% vs. 85.1% among males) and were significantly more likely to believe that talking about suicide in the classroom makes some kids more likely to try to kill themselves (26.7% vs. 11.5% in the overall sample and 40.0% vs. 13.8% among males). Attempters were also more likely to feel that the program would make it harder for them to deal with their friends' problems (50.0% vs. 1.0%). There was also some evidence that previous attempters were upset by the programs more than their nonattempter peers.

Results from the study indicate that the programs studied were ineffective in altering the deviant attitudes held by suicide attempters. Findings show educational programs do not generally set out to identify and reach high-risk individuals, and their ability to influence

the high-risk individuals who are in their audiences is limited. It is suggested that more work needs to be done in identification of individuals at risk and in individualizing evaluation and intervention.

Keywords: Identification
Program evaluation
School programs

36. Smaby, M.H., Peterson, T.L., Bergmann, P.E. et al. "School-Based Community Intervention: The School Counselor as Lead Consultant for Suicide Prevention and Intervention Programs." *School Counselor*, 37 (1990):370-377.

Using a developmental framework that views all learner-at-risk behaviors (alcohol and other drug abuse, high-risk sexual practices, and depression and suicidal behavior) as indicators of lack of skills for accomplishing normal developmental tasks, the authors advocate using school and community resources in programs of prevention aimed at all teenagers, not just those who attempt suicide or who appear to be most at risk.

It is suggested that the school counselor see at-risk prevention and intervention as necessary components of developmental guidance. The thrust of the school-based intervention program should be on teaching students life skills, not remediating psychopathology. Counselors are urged to see their roles as extending beyond direct provision of services to students in their schools to implementing collaborative community efforts.

The elements of the school-based community intervention approach related to suicide are:

1. Initial organizational leadership from school personnel.
2. Awareness of the extent of adolescent suicide and depression in their own school and community.
3. Identification of characteristics and symptoms of depression and suicidal tendency.
4. Integration and understanding of associated risk factors (e.g. alcohol and drug abuse).
5. Understanding natural adolescent developmental tasks and the potential stressors with which the adolescent must attempt to cope.

The manner in which such a program could be implemented is presented through a case example of the "content helping" consultative approach used in a group of Minnesota schools. The content-helping consultative approach sends school counselors to find outside resource persons to assist them in providing information/training that is not available in the school setting. In the case example, learner-at-risk intervention teams from several rural Minnesota school districts cooperated to contract for technical assistance in getting training on depression and suicide, alcohol and other drug abuse, and sexual acting out. The teams received the training in the form of five 2-day workshops. The purpose was to create active school-based community intervention teams, networks for using community mental health resources, and trained school personnel who can in turn provide inservice for colleagues in their respective schools.

Keywords: Community programs
Counseling
Intervention strategies
School programs

37. Spirito, A., Overholser, J., Ashworth, S., Morgan, J. et al. "Evaluation of a Suicide Awareness Curriculum for High School Students." *Journal of the American Academy of Child and Adolescent Psychiatry*, 27(6) (1988):705-711.

Suicide awareness programs have become increasingly commonplace in high school curricula, yet controversy exists over their risks and benefits. This study was designed to assess both positive and negative outcomes of a suicide awareness program for ninth graders, a curriculum of the Samaritans of Rhode Island. Students' knowledge, attitudes, coping styles, hopelessness, and helping behaviors were assessed before and 10 weeks after completion of a program consisting of sessions on attitudes about suicide, facts and risk factors, identification, intervention, and referral techniques. A control group was also used.

The experimental group displayed small, but significantly greater, increases in certain coping strategies and knowledge than did the controls, and the experimental group also showed a decrease in hopelessness. Knowledge about suicide also appeared to increase simply by pretest sensitization. Females were more likely than males to show an understanding of suicidal behavior regardless of whether or not they took part in the suicide awareness program. Girls were also found to be much more likely than boys to refer someone for counseling due to suicidal ideation although the curriculum did not seem to have any effect on this tendency for girls to refer. The curriculum was found to have no negative effect on knowledge about suicide, helping attitudes, or hopelessness.

Keywords: Gender differences
Program evaluation
School programs

38. Taylor-Mearhoff, C. *Suicide Prevention: The Student Assistance Model.* (1990). (ERIC Document Reproduction Service No. ED 332 410).

The Roberts Assistance Program (RAP), a model program for student assistance and suicide prevention established in 1988 by the Owen J. Roberts School District in Chester County, Pennsylvania, provides services to students in kindergarten through grade 12. Core teams of school professionals receive student assistance program (SAP) training to identify and intervene with students who are at risk for a variety of harmful behaviors, including substance abuse, depression, suicide, eating disorders, and other emotional concerns. Teams consist of a building administrator, counselor, nurse, several teachers, and the coordinator of student assistance programs and services.

Prevention services offered by RAP have an educational component, including a K-12 prevention curriculum for students, faculty in-service programs, and community education.

Intervention services include the use of crisis response teams and the establishment of specific procedural guidelines to provide early referral for students who are experiencing substance abuse, depression, suicide risk, family dysfunction, and other mental health issues, and to address drug and alcohol and suicide emergencies.

Postvention services are designed to enable school personnel to provide a sense of calm and security for students during the aftermath of a tragedy. Postvention guidelines have been established for administrators, teachers, support staff, individuals at drop-in centers, and the crisis response team. Guidelines outline notification procedures, postvention services, and follow-up strategies. An evaluation of the program revealed that 92% of students believed that the schools should provide such services.

Keywords: Intervention strategies
Postvention
School programs

39. Wynne, E.A. "Preventing Youth Suicide Through Education." In *Report of the Secretary's Task Force on Youth Suicide, Volume 4: Strategies for the Prevention of Youth Suicide*, Alcohol, Drug Abuse and Mental Health Administration. Public Health Service, DHHS Publication Number (ADM) 89-1624 Washington, D.C.: U.S. Government Printing Office. (1989).

The rise in adolescent suicides is paralleled by increases in other indicators of "youth disorder": out-of-wedlock births; homicides; drug and alcohol use; and adolescent sexual activity. These increases include allowances for changes in the levels of youth in the population. The author suggests that it's implausible to assume that adolescent suicide and each of these other indicators of youth disorder has its own discrete causes and variables with no overlap. The problem is not teen suicide; rather it is "the overall increase in youth disorder."

Suicide prevention programs that target at-risk youth for intervention will identify many youth who will not attempt suicide because the known suicidal indicators are imprecise, but these nonsuicidal teens will be among those at risk for other forms of disorder. Therefore, it is suggested that instead of an adolescent suicide prevention program, a program for overall emotional health should be implemented.

It is suggested that schools and colleges also look at themselves to see if they have inadvertently contributed to the rise in youth disorder. For instance, it is noted that evaluations of school-based suicide prevention programs are rare, and one researcher is quoted as stating that in implementing prevention programs, "People are making rash generalizations. They are not admitting to themselves how much knowledge they don't have, and they're basing programs on that which may or may not be harmful, never mind helpful."

Drawing on years of use and evaluation of other programs designed to change student attitudes such as drug and sex education and values clarification programs, general principles about the development and evaluation of school-based suicide prevention programs are presented.

Durkheim's analysis of the underlying cause of suicide (not being needed) is applied to present-day teen suicide and the roles schools must play in helping teens feel and be useful. An argument for an environmental approach to decreasing youth disorder and improving mental health overall by improving the total environment of the school is advanced, and eleven principles for a desirable school environment are presented. These principles are:

1. Adults clearly maintain responsibility and authority for school management.
2. The school is dedicated to fostering cognitive learning, good discipline, and wholesome pupil emotional development.
3. Pupils are put under significant pressure to actively pursue the goal established by the school.

4. The adults in the schools work together closely to attain its goals.
5. Pupils spend substantial periods of time in discrete, smaller, persisting groups under general adult supervision. Examples are self-contained classrooms, homerooms, and athletic teams.
6. Pupils are given a sense of being needed and are encouraged to perform community service projects.
7. The school maintains a powerful system of reward and punishment.
8. Pupils, depending on their age, have notable input in school policies in certain appropriate areas.
9. The school maintains relative student and staff stability.
10. The school uses ceremonies and rituals as one means to enhance the sense of community of the school community.
11. These goals and practices are generally understood and accepted by the entire school community.

Seven research and policy recommendations are presented, including a call for more research funding on suicide prevention programs and a statement that, at present, insufficient information is available on programs of school-related suicide prevention, so the Federal government is precluded from approving one. Further research is also needed on school wholesomeness and on how to transform "environmentally disordered" schools. A call is also made for the government to publicly recognize the general overall rise in youth disorder; to fund data collection, research, and theoretical analysis aimed at exploring causes and solutions; and to acknowledge and study the possible connection between various forms of youth disorder and teen suicide.

Keywords: Prevention strategies
Program evaluation
School climate
School programs

Keyword Index

Keyword Index

(Articles referenced by article number)

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School and Community Suicide Prevention Program Development Materials

CURRICULA AND PROGRAM MANUALS
(All prices subject to change.)

Adolescent Suicide: A Teacher's Curriculum and Guide
($10.00)
Help Hotline
P.O. Box 46
Youngstown, OH 44501
(216) 747-5111

Adolescent Suicide Awareness Program Manual: A Comprehensive Education & Prevention Program For School Communities
South Bergen Mental Health Center, Inc.
646B Valley Brook Avenue
Lyndhurst, NJ 07071
(201) 460-3510

Adolescent Suicide Prevention Program: A Guide for Schools and Communities
($7.00)
Fairfax County Schools
c/o Myra Herbert
Belle Willard Administrative Center
10310 Layton Hall Drive
Fairfax, VA 22030
(703) 246-7745

"Choosing Life: Adolescent Suicide in Literature."
(Discusses the use of young adult fiction on suicide. Includes a bibliography of novels.)
by G.H. Swing.
in *English Journal,* September 1990, 78-82.

Entering Adulthood: Understanding Depression and Suicide: A Curriculum for Grades 9-12, (1990)
($19.95)
by Nanette D. Burton
Network Publications
P.O. Box 1830
Santa Cruz, CA 95061-1830
(800) 321-4407

In His Brother's Footsteps
California Department of Mental Health
1600 9th St.
Sacramento, CA 95814
Suicide prevention curriculum for grades 7-12.

Lifesaver Program Manual: Child and Adolescent Suicide Prevention in School Systems, (1988)
($30.00)
Suicide Prevention Center
P.O. Box 1393
Dayton, OH 45401-1393
(513) 297-9096

Peer Counseling: In-Depth Look at Training Peer Helpers
($15.95)
Peer Power, Book 1: Becoming an Effective Peer Helper
($13.95)
Peer Power, Book 2: Applying Peer Helper Skills
($13.95)
by Judith A. Tindall
Accelerated Development, Inc.
3400 Kilgore Avenue
Muncie, IN 47304-4896
(317) 284-7511

Project SOAR (Suicide: Options, Awareness, and Relief) Program Description
Dallas Independent School District
Psychological/Social Services
1401 South Akard
Dallas, TX 75215
(214) 565-6700

SOS Training Manual
($20.00)
Opportunity Development Center
Book Distribution Department
1911 Huntington St.
Wisconsin Rapids, WA 54494

Student Assistance Model Manual, (1985, to be revised)
($20.00)
Wheeler Clinic, Prevention Unit
334 Farmington Avenue
Plainville, CT 06062
(203) 793-2164

Student Assistance Program: Practical Guidelines for Schools, (1990)
Pennsylvania Department of Education
c/o Sandy Rakar, Student Assistance Network Coordinator
333 Market Street
Harrisburg, PA 17126-0333
(717) 783-6790

Suicide Prevention: A Crisis Intervention Curriculum, (1989)
by J. Smith
Deaconess Press
2450 Riverside Ave. S
Minneapolis, MN 55454-1336
(612) 337-4180

Student Suicide: A Guide for Intervention
($7.95)
by John A. Vidal
stock no. 0244-X-00KM
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Also available from ERIC Document Reproduction Service
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Suicide Prevention: A Crisis Intervention Curriculum For Teenagers and Young Adults, (1989)
($14.95 plus $2.75 shipping)
by Judie Smith
Learning Publications
P.O. Box 1338
Holmes Beach, FL 34218
(813) 778-6651

Suicide Prevention: A Guide to Curriculum Planning, Bulletin No. 0500
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Suicide Prevention Program for California Public Schools, (1987)
($8.48)
(Includes curriculum for grades 9-12 and guides for parent and teacher awareness.)
California State Department of Education
Publication Sales
P.O. Box 271
Sacramento, CA 95802
(916) 322-2848

A Teacher's Manual For the Prevention of Suicide Among Adolescents
($15.00)
The Samaritans, Inc.
2 Magee Street
Providence, RI 02906
(401) 272-4243

Understanding Depression and Suicide, (1990).
($19.95)
by N. Burton
ETR Associates/Network Publications
P.O. Box 1830
Santa Cruz, CA 95061-1830
(408) 438-4060

Youth Suicide: A Comprehensive Manual for Prevention and Intervention, (1990)
($19.95)
by Barbara Barrett Hicks
National Educational Service
1621 W. Third Street
P.O. Box 8
Bloomington, IN 47402
(812) 336-7701

Youth Suicide Prevention School Program for the Public Schools of Maryland, (1987)
Maryland State Department of Education
Division of Compensatory, Urban, and Supplementary Programs
200 West Baltimore Street
Baltimore, MD 21201

Youth Suicide: A School Approach for the Prevention of Youth Suicide in Indiana
by Josephine Osborne
Indiana State Board of Health
Indianapolis, IN
Also available from ERIC Document Reproduction Service
No. ED 279 930
(800) 227-ERIC, (703) 823-0500

BOOKS AND OTHER MATERIALS
(All prices subject to change.)

Adolescent Suicide: Identification and Intervention
Community Intervention, Inc.
529 S. 7th St., Suite 570
Minneapolis, MN 55415-1657
(800) 328-0417

At Risk Youth in Crisis: A Handbook for Collaboration Between Schools and Social Services, Volume 2: Suicide
($7.50)
University of Oregon
1787 Agate St.
Eugene, OR 97403-1923

The California Helper's Handbook for Suicide Intervention
California Department of Public Health
1600 9th St.
Sacramento, CA 95814
(916) 654-2624

Counseling/Intervention Strategies for Suicide Prevention, (1988).
by D. Capuzzi
ERIC Counseling & Personnel Services Clearinghouse
University of Michigan
Ann Arbor, MI 48109-0001
(313) 763-1817

Everything You Need to Know About Youth Suicide
($64.95)
(Video intended for teens)
Network Publications
P.O. Box 1830
Santa Cruz, CA 95061-1830
(800) 321-4407

For a Better Tomorrow: A Plan for Youth Suicide Prevention in Maryland
Governor's Task Force on Youth Suicide
c/o Mental Hygiene Administration
201 West Preston Street, Room 414
Baltimore, MD 21201
(410) 225-5060

How to Fight Teenage Suicide: A Parents' Guide to the Danger Signals
by David A. Friedo
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The University of Michigan Medical Center
Ann Arbor, MI
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Not With My Life I Don't: Preventing Your Suicide and That of Others, (1988)
($17.95)
(for teenagers and parents)
by Howard Rosenthal
Accelerated Development, Inc.
3400 Kilgore Avenue
Muncie, IN 47304-4896
(317) 284-7511

Planning to Live
($24.95)
National Resource Center for Youth Services
202 W. Eighth
Tulsa, OK 74119-1419
(918) 585-2986
FAX (918) 592-1841

Preventing Adolescent Suicide, (1988)
($24.95)
by Dave Capuzzi and Larry Golden
Accelerated Development, Inc.
3400 Kilgore Avenue
Muncie, IN 47304-4896
(317) 284-7511

Preventing Chaos in Times of Crisis: A Guide for School Administrators
($12.00)
Association for California School Administrators
Communications Department
1517 L Street
Sacramento, CA 95814

Preventing Teenage Suicide: The Living Alternative Handbook
(Hardcover $29.95; softcover $18.95)
by Polly Joan
Human Sciences Press
Available from Plenum Publishing Corp.
233 Spring Street
New York, NY 10013
(212) 620-8000

Prevention of Mental Disorders, Alcohol, and Other Drug Use in Children and Adolescents, (1990). OSAP Prevention Monograph-2.
Eds. David Shaffer, et.al.
Center for Substance Abuse Prevention
Rockville, MD
(800) 729-6686
Summarizes the knowledge base on prevention of alcohol and other drug use and mental disorders in children and adolescents. Relevent chapters include "Commentary: The Integration of Problem and Prevention Perspectives: Mental Disorders Associated with Alcohol and Drug Use" and "Prevention Issues in Youth Suicide."

Report of the Secretary's Task Force on Youth Suicide, (1989)
Volume 1 - Overview and Recommendations
Volume 2 - Risk Factors for Youth Suicide
Volume 3 - Prevention and Intervention in Youth Suicide
Volume 4 - Strategies for the Future
U.S. Government Printing Office
Washington, D.C.
(202) 275-3648

The Suicidal Tendencies Scale
(A quick screening identification instrument for teachers, counselors, clergy and others.)
by John A. Crocitto
in *School Counselor*, 37(5) (1990):324-327.

Suicide Intervention in the Schools, (1989)
($19.95)
by Scott Poland
Guilford Publications, Inc.
72 Spring Street
New York, NY 10012
(212) 431-9800

Suicide Over the Life Cycle: Risk Factors, Assessment, & Treatment of Suicidal Patients, (1990).
S.J. Blumenthal and D.J. Kupfer (Eds.).
American Psychiatric Press
Washington, DC
(800) 368-5777, (202) 682-6262.
Includes chapters "Substance Abuse and Suicidal Behavior," The Assessment and Treatment of Children and Adolescents at Risk for Suicide," and "Community Strategies for Suicide Prevention and Intervention." Each provides an overview of the relevant clinical research and suggests prevention and intervention approaches.

Suicide Prevention in Schools
($53.00 hardcover; $29.95 softcover)
Antoon Leenaars, Ed.
Hemisphere Publications
1900 Frost Road, Suite 101
Bristol, PA 19007
(800) 821-8312

Teen Suicide: A Guide to Understanding Adolescents, (1987)
by J.A. Jones
Minerva Press, Inc.
6653 Andersonville Rd.
Waterford, MI 48095

Teen Suicide Prevention: Computer-Based Training and Reference Library
($75.00)
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The Troubled Journey
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Search Institute
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Minneapolis, MN 55404
(612) 870-9511

Youth at Risk: A Resource for Counselors, Teachers and Parents. Part 3: Working with Youth at Risk: Behavioral Issues and Interventions. (1989).
by Frances A. Kemply, et. al.
American Association for Counseling and Development
Alexandria, VA
(703) 823-9800
Available from ERIC Document Reproduction Service
No. ED 323 457.
This book contains a chapter on suicidal behavior ("I Don't Want to Live: Suicidal Behavior" by Dave Capuzzi & Douglas Gross) which considers the extent of the problem, signs and symptoms, causes and treatments.

Youth in Crisis: Seeking Solutions to Self-Destructive Behavior
($29.95 plus $3.00 shipping)
by Tom Barrett
Sopris West, Inc.
P.O. Box 1809
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(303) 651-2829

Youth Suicide: A Catalogue of Audio-Visual Resources, 1965-1987, (1988)
($4.00)
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Youth Suicide Prevention in Vermont: The Lieutenant Governor's Task Force, (1988)
Vermont State Department of Education
Montpelier, VT
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Youth Suicide Prevention Programs: A Resource Guide, (1992), (Free)
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Mailstop F36
4770 Buford Highway NE
Atlanta, GA 30341-3724
(404) 639-3311

RESOURCE CENTERS

American Association of Suicidology
2459 South Ash
Denver, CO 80222
(303) 692-0985
Books and other publications.
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Connecticut Clearinghouse for Substance Abuse Prevention
(800) 232-4424
Lending library of prevention materials (books, videos, curricula). Special section devoted to youth suicide prevention.

National Model Adolescent Suicide Prevention Project
Ms. Pat Serna
Jicarilla Apache Tribe
P.O. Box 546
Dulce, NM 87528
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National Resource Center for Youth Services
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Offers a bibliography on suicide prevention in the schools.
(Reading list is free. Data base search on topics in suicide is $25.00.)