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# PREVENTING SUICIDE: INFORMATION FOR CAREGIVERS AND EDUCATORS

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Suicide is the third leading cause of death among youth age 10–19. More than a quarter of high school teachers report that they have been confronted with a student's suicidal behavior. This handout is designed to provide caregivers with information important to the prevention of these behaviors, including a review of basic suicide facts, risk factors, warning signs, and possible interventions.

## Suicide Facts

Suicidal behaviors are self-inflicted injuries undertaken with conscious thoughts of ending one's own life. These behaviors may be either fatal (completed suicide) or non-fatal (attempted suicide). Although there are no official statistics, it is estimated that in 2000 there were more than 700,000 attempted suicides in the United States. More than 29,000 people completed suicides, making suicide the eleventh leading cause of death.

**Attempts versus completions.** Whereas the ratio of suicide attempts to suicide completions was 4:1 for the elderly population, it was estimated to be as high as 200:1 for youth. The Youth Risk Behavior Surveillance (YRBS) 2001 data indicated for every three youths who attempted suicide, only one reported actually receiving medical attention for injury. Gay and lesbian youths are 200–300% more likely to attempt suicide than other young people and may account for up to 30% of completed youth suicides.

**Youth suicide.** There were 1,921 suicides among youth between the ages of 10 and 19 in 2000. Only accidents and homicides took more young lives. Suicide is very rare among children under the age of 14: In 2000 there were 300 suicides in the 10–14 age group. Suicide did not rank as a leading cause of death under the age of 10.

**Ethnicity.** While Native American males had the highest rate of youth suicide reported in 2000, overall African American male adolescents (15–24) have shown the greatest increase in suicide completion rates in the last decade relative to other races and ethnicities.

**Gender.** Males are four times more likely to complete suicide than females. However, females are more likely to *attempt* suicide. It is estimated that in 2000 there were three female suicide attempts for every male suicide attempt.

## Suicide Risk Factors

While the path that leads to suicidal behavior is long and complex (there are probably as many causes of suicide as there are suicide victims), and there is no profile that predicts suicidal behavior with certainty, there are certain risk factors associated with increased suicide risk. In isolation, these factors are not signs of suicidal thinking. However, when present these factors indicate the need to be vigilant:

- **Mental illness:** Approximately 90% of suicides are associated with mental or addictive disorders. Among youth, affective disorders (especially depression), conduct disorders, and substance abuse are common among those who display suicidal behaviors.
- **Family stress/dysfunction:** A family history of suicide and/or mental illness is associated with increased suicide risk. In addition, youth from homes that are perceived as lacking cohesion and having more conflict and violence (for instance, chaotic home environments) are at increased risk for suicidal behavior.
- **Environmental risks:** The presence of a firearm in the home is a risk factor for suicide.
- **Situational crises:** Approximately 40% of all youth suicides are associated with an identifiable

precipitating event. The types of crises associated with suicidal behavior are those that result in a subjective sense of loss (for instance, traumatic death of a significant other, the suicide of a significant other, parental divorce, physical and sexual abuse, incarceration, family violence). For most people these situational crises alone are not sufficient to result in suicidal behavior. It is only when these situational crises are combined with other risk factors that suicidal behavior occurs.

## Suicide Warning Signs

Warning signs are observable behaviors that may signal the presence of suicidal thinking. They may be considered cries for help or invitations to intervene:

- *Suicide threats:* It has been estimated that 80% of all suicide victims have given some clues regarding their intentions. Both direct (“I want to kill myself.”) and indirect (“I wish I could fall asleep and never wake up.”) threats need to be taken seriously.
- *Suicide notes and plans:* The presence of a suicide note is a very significant sign of danger. The greater the planning revealed by the youth, the greater the risk of suicidal behavior.
- *Prior suicidal behavior:* Prior behavior is a powerful predictor of future behavior. Therefore, anyone with a history of suicidal behavior should be carefully observed for future suicidal behavior.
- *Making final arrangements:* Making funeral arrangements, writing a will, and/or giving away prized possessions may be warning signs of impending suicidal behavior.
- *Preoccupation with death:* Excessive talking, drawing, reading, and/or writing about death may suggest suicidal thinking.
- *Changes in behavior, appearance, thoughts, and/or feelings:* Depression (especially when combined with hopelessness), sudden happiness (especially when preceded by significant depression), a move toward social isolation, giving away personal possessions, and reduced interest in previously important activities are among the changes considered to be suicide warning signs.

## Intervening to Prevent Suicide

When you see suicide warning signs, immediately ask whether the individual has suicidal thoughts. Be direct. For example: “Sometimes when people have your experiences and feelings, they have thoughts of suicide. Is this something you have thought about?” Failure to ask directly (saying, “You are not thinking of hurting yourself are you?”) may not give the needed permission

to acknowledge suicidal thinking. When an individual acknowledges having thoughts of suicide, the following interventions should be undertaken:

- *Remain calm:* Becoming too excited or distressed will communicate that the potential caregiver is not able to talk about suicide.
- *Listen:* Allow for the discussion of experiences, thoughts, and feelings. Be prepared for expression of intense feelings.
- *Do not judge:* Try to understand the reasons for considering suicide without taking a position about whether or not the behavior is justified.
- *Provide constant supervision:* Especially when working with youth, do not leave the individual alone until a caregiver (often a parent) has been contacted and agrees to provide appropriate supervision.
- *Remove means:* As long as it does not put the caregiver in danger, attempt to remove the suicide means.
- *Get help:* For students this means not agreeing to keep the suicidal thinking of a friend a secret. Tell an adult or involve school mental health professionals, such as a school psychologist, as soon as possible. For parents and other adult caregivers getting help means taking action immediately. Seek guidance and support from school or community mental health resources.

## School Suicide Prevention

The following key points summarize the school’s role in preventing suicide:

**Detection/awareness.** The entire school community (including students, parents, teachers, paraprofessionals, administrators, support staff, bus drivers, cafeteria workers) who interact with students on a regular basis must know the risk factors and warning signs of suicide described above and the importance of not keeping a secret about suicidal behavior. Some schools establish contracts among students and staff whereby everyone agrees to appropriately report indications that a student is suicidal. Suicide prevention curricula are available and should be considered as additions to the regular school curriculum.

**Parent notification.** It is essential that school personnel who are aware that a student is suicidal immediately contact the student’s parents. Ideally, this contact should be made in a face-to-face meeting and should include recommendations to parents about increasing supervision, removing lethal means, and referral to community services. The school must maintain a documented record of parent notifications.

**Support for suicidal students.** Support must be provided by school personnel such as psychologists and counselors in the form of regular counseling, monitoring, and follow-up and referral services to assist those students known to be suicidal. One recommended form of support is a *no suicide contract* between the student and mental health professional, which helps suicidal students gain control over their impulses as well as serving as a means of assessing the degree of suicidal threat.

## Concluding Comments

Most youth who think about suicide do not go on to kill themselves. While it is possible that a suicidal youth will die by suicide, if suicidal intentions can be recognized and appropriate interventions offered it is probable that youth who are thinking about suicide will not kill themselves.

However, there are no easy solutions to the problems that lead to suicidal thinking and behavior. While it is typically not possible nor appropriate to stop an individual from thinking about suicide, it is possible to prevent the immediate risk of self-injurious behavior, and in doing so to obtain the time needed for the suicidal individual to get the professional help needed.

## Resources

- American Association of Suicidology. (n.d.). *About suicide*. Available:  
[www.suicidology.org/displaycommon.cfm?an=2](http://www.suicidology.org/displaycommon.cfm?an=2)
- American Association of Suicidology (1999). *Guidelines for school-based suicide prevention programs*. Washington, DC: Author. Available:  
[www.suicidology.org/associations/1045/files/School%20guidelines.pdf](http://www.suicidology.org/associations/1045/files/School%20guidelines.pdf)
- Brock, S. E., Lazarus, P. J., & Jimerson, S. R. (Eds.) (2002). *Best practices in school crisis prevention and intervention*. Bethesda, MD: National Association of School Psychologists. ISBN: 0-932955-84-3.
- Brock, S. E., & Sandoval, J. (1997). Suicidal ideation and behaviors. In G. Bear, K. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 361–374). Bethesda, MD: National Association of School Psychologists. ISBN: 0-932955-96-7.
- Brock, S. E., Sandoval, J., & Lewis, S. (2001). *Preparing for crises in the schools: A manual for building school crisis response teams* (2<sup>nd</sup> ed.). New York: Wiley. ISBN: 0471384232.
- Davis, J. M., & Brock, S. E., (2002). Suicide. In J. Sandoval (Ed.), *Handbook of crisis counseling, intervention and prevention in the schools* (pp. 273–300). Mahwah, NJ: Erlbaum. ISBN: 0805836160.
- Leane, W., & Shute, R. (1998). Youth suicide: The know-

- ledge and attitudes of Australian teachers and clergy. *Suicide and Life Threatening Behavior*, 26, 123–133.
- Lieberman, R., & Davis, J. M. (2002). Suicide intervention. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and intervention* (pp. 531–552). Bethesda, MD: National Association of School Psychologists. ISBN: 0-932955-84-3.
- Miniño, A. M., Arias, E., Kochanek, K. E., Murphy, S. L., & Smith, B. L. (2002). Deaths: Final data for 2000. *National Vital Statistics Reports*, 50 (15).
- McIntosh, J. L. (2002, September 21). *U.S.A. suicide: 2000 official final data*. Retrieved February 1, 2003, from: [www.suicidology.org](http://www.suicidology.org)
- Poland, S., & Lieberman, R. (2002). Suicide intervention. In Thomas, A. & Grimes, J. (Eds.), *Best practices in school psychology IV* (pp. 1151–1166). Bethesda, MD: National Association of School Psychologists. ISBN: 0-932955-85-1.
- Sandoval, J., & Brock, S. E. (1996). The school psychologist's role in suicide prevention. *School Psychology Quarterly*, 11, 169–185.

## Websites

- American Association of Suicidology—[www.suicidology.org](http://www.suicidology.org)
- National Hopeline Network—[www.hopeline.com](http://www.hopeline.com) (1-800-SUICIDE; 24-7 access to trained telephone counselors)
- National Institute of Mental Health—  
[www.nimh.nih.gov/publicat/depsuicideemenu.cfm](http://www.nimh.nih.gov/publicat/depsuicideemenu.cfm)
- Suicide Awareness Voices of Education (SAVE)—  
[www.save.org](http://www.save.org)
- Suicide Information and Education Center—[www.siec.ca](http://www.siec.ca)
- Yellow Ribbon Suicide Prevention Program—  
[www.yellowribbon.org](http://www.yellowribbon.org)
- SOS High School Suicide Intervention Program—  
[www.mentalhealthscreening.org](http://www.mentalhealthscreening.org)

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