Handbook of School Violence and School Safety
International Research and Practice
Shane R. Jimerson, Amanda B. Nickerson, Matthew J. Mayer, Michael J. Furlong

Youth Suicidal Behavior in the Context of School Violence

Publication details
David N. Miller
Published online on: 05 Dec 2011

How to cite: - David N. Miller. 05 Dec 2011, Youth Suicidal Behavior in the Context of School Violence from: Handbook of School Violence and School Safety, International Research and Practice Routledge
Accessed on: 27 Oct 2023

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: https://www.routledgehandbooks.com/legal-notices/terms

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.
Youth Suicidal Behavior in the Context of School Violence

David N. Miller
UNIVERSITY AT ALBANY, STATE UNIVERSITY OF NEW YORK

Abstract

Youth suicidal behavior is a significant public health problem. According to the World Health Organization, suicide has increased over 60% worldwide during the last half-century, and is the second leading cause of death among young people ages 10 to 24 in the world (Miller, 2011). In the United States, although suicide is the 11th leading cause of death among Americans overall, it is the fourth leading cause of death among children and early adolescents ages 10 to 14, and the third leading cause of death among adolescents ages 15 to 19 (Miller & Eckert, 2009). Moreover, although death rates of children and adolescents have decreased steadily and substantially during the last several decades as a result of continuing medical advances, the youth suicide rate in the United States has remained consistently high (King & Apter, 2003).

Despite fluctuating rates of youth suicide over the last several years, including notable decreases during the 1990s and early 21st century, the overall suicide rate for children and adolescents has increased over 300% in the last 50 years (Berman, Jobes, & Silverman, 2006), and some believe it is likely to further increase in the future (e.g., Gutierrez & Osman, 2008). Adding to these sobering statistics is the possibility that the number of reported youth suicides may be an underestimate of their actual occurrence (Lieberman, Poland, & Cassel, 2008). Although research indicates that if underreporting of youth suicides does take place it is likely to be fairly minimal...
(Kleck, 1988), the stigma that surrounds suicide (Joiner, 2005) suggests that some degree of underreporting may well occur.

The unacceptably high number of annual youth suicides that occur in the United States and other countries, however, is only part of the problem. For every youth who dies by suicide, it is estimated that at least 100 to 200 young people make suicide attempts, and thousands more engage in serious thoughts about killing themselves (Miller & Eckert, 2009). Moreover, children and adolescents who seriously contemplate or attempt suicide often experience depression and other mental health issues, and family and friends of suicidal youth are also at risk for developing these problems (Miller, 2011). As a result, the psychological, emotional, behavioral, social, medical, and financial cost of youth suicidal behavior, not only for individuals but also for families and entire communities, is frequently devastating (Miller, Eckert, & Mazza, 2009).

Because school personnel have such frequent contact with children and adolescents, they are ideally and uniquely positioned to prevent youth suicide (Miller, 2011). Many schools have experienced a significant increase in the amount of referrals for students who are seriously depressed, self-injurious, and/or suicidal, and this trend appears likely to continue (Lieberman et al., 2008). Unfortunately, many school personnel do not appear adequately trained to provide needed services for these children and adolescents (Miller & Jome, 2010). These issues are critical, because the manner in which school practitioners respond to suicidal youth can literally mean the difference between life and death (Miller & Eckert, 2009).

Despite the problem of youth suicidal behavior and the urgent need to address it, historically this topic has not received significant attention in the school violence literature. For example, in the first edition of the *Handbook of School Violence and School Safety* (Jimerson & Furlong, 2006), the topic of youth suicide was mentioned only in the context of conducting a threat of violence risk assessment toward others (Van Dyke & Schroeder, 2006). Given that the prevention of self-directed youth violence is at least as important as preventing youth violence directed toward others, the conceptualization of school violence can and should be broadened to include self-destructive behavior, including suicidal behavior. Although most youth suicides occur in a student’s home or in a place outside of school, youth suicidal ideation, suicide-related communication, and even suicide attempts can and does occur in school settings.

The purpose of this chapter is to provide a brief overview of youth suicidal behavior. Demographic information regarding youth suicidal behavior is provided, as well as information regarding protective factors, risk factors, warning signs, and the issue of suicide “contagion.” In addition, the relationship between youth suicidal behavior and school violence—in the form of school shootings—is briefly summarized. First, however, it is necessary to define suicidal behavior and precisely what is meant by that term.

**Suicidal Behavior**

For the purposes of this chapter, *suicidal behavior* will refer to four separate but frequently overlapping conditions that exist on a continuum, including suicidal ideation, suicide-related communications, suicide attempts, and suicide. The behaviors along this continuum vary and are not mutually exclusive, nor do all suicidal youth advance through them sequentially (Mazza, 2006; Silverman, Berman, Sanddal, O’Carroll, & Joiner, 2007a,b). Further, although the frequency of each behavior decreases as individuals move along this continuum, the level of lethality and probability of death increases (Mazza & Reynolds, 2008). Consequently, suicidal behavior includes and incorporates a much larger set of behaviors than suicide alone. Each of these four types of suicidal behavior is described below.
**Suicidal Ideation**

Suicidal ideation occurs at the beginning of the suicidal behavior continuum, and refers to cognitions or thoughts about suicide. These cognitions may range from more general thoughts such as wishes about never being born or about being dead, to more specific thoughts such as developing detailed plans regarding when, where, and how suicide might occur (Mazza, 2006). Transient thoughts about suicide appear to be quite common and even somewhat normative during adolescence (Rueter, Holm, McGeorge, & Conger, 2008). Research also indicates that the prevalence of suicidal ideation increases as children grow older, peaking at about age 14 through 16 and declining thereafter (Rueter & Kwon, 2005). Suicidal ideation becomes clinically significant when it is more than transient, when it is possibly a preoccupation, and when it is accompanied by an increased probability of behavioral action (Berman et al., 2006).

**Suicide-Related Communications**

Suicide-related communications refer to any interpersonal act of imparting, conveying, or transmitting thoughts, wishes, desires, or interest about suicide (Silverman et al., 2007b). This category includes both verbal and nonverbal communications that may have suicidal intent but result in no life-threatening outcomes for the individual. Within this category are two subsets: suicide threat and suicide plan.

A **suicide threat** refers to any interpersonal verbal or nonverbal action, without a direct self-injurious component, that a reasonable person would interpret as communicating or suggesting that more extreme forms of suicidal behavior might occur in the near future (Silverman et al., 2007b). This communication may be either direct (e.g., a student telling one of his peers that he wants to kill himself) or indirect (e.g., a student engaging in highly dangerous, risky, and self-destructive behavior), and varies in regards to level of planning, communication, and concealment from others (Kingsbury, 1993). A **suicide plan** refers to a proposed method of carrying out a design that will lead to suicide or a potentially self-injurious outcome (Silverman et al., 2007b). Both suicide threats and suicide plans communicate a clear intent to die, and should always “be taken seriously, responded to, and evaluated as indicators of potential clinical significance and potential risk” (Berman et al., 2006, p. 99).

**Suicide Attempts**

A suicide attempt is the third form of suicidal behavior on this continuum, and may be defined as a self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is either implicit or explicit evidence of the intent to die (Silverman et al., 2007b). There are different types of suicide attempts, with some being considered **high-intent attempts** and others considered **low-intent attempts**. What distinguishes these two types is generally the level of lethality of the method used in making the attempt (Berman et al., 2006). For example, high-intent suicide attempts are associated with higher levels of lethality (e.g., the use of guns).

Most suicide attempts made by children and adolescents are of low lethality, allowing for a higher probability of rescue. In fact, the great majority of youth suicide attempts (approximately seven out of every eight) are of such low lethality as to not require medical or other forms of attention, and many suicide attempts are never even reported (Berman et al., 2006). Although most youth who attempt suicide will do so only once and not die as a result, a substantial number of individuals who attempt suicide later die by it (Berman et al., 2006). Further, engaging in a suicide attempt places youth at risk for a host of other mental health problems even if it does not result in eventual suicide (Groholt & Ekeberg, 2009).
Suicide

Suicide is the last and obviously the most lethal behavior on the suicidal behavior continuum (Mazza & Reynolds, 2008). Suicide may be defined as a fatal, self-inflicted act with the explicit or inferred intent to die (Mazza, 2006). The determination of intentionality is often difficult, and rests on evidence that the decedent (i.e., individual who died) understood that the self-inflicted act would produce death.

Finally, it should be noted that the profiles of individuals who engage in different forms of suicidal behavior vary significantly. For example, the typical youth who attempts suicide is an adolescent female who ingests drugs at home in front of others (e.g., parents), whereas the typical youth who dies by suicide is an adolescent male using a firearm (Berman et al., 2006). A common element shared by young people who engage in any form of suicidal behavior, however, is that these children and adolescents are exhibiting serious and significant problems to a degree that will require urgent attention and active intervention on the part of caring adults, particularly those working in schools.

Demographics of Youth Suicide

Ethnicity

Various ethnic groups differ in their rates of youth suicide, the context in which suicide occurs, and in their patterns of help seeking (Goldston et al., 2008). Among the larger ethnic groups in the United States, European Americans have the highest youth suicide rate, followed by African Americans and Latinos (Berman et al., 2006). The highest rates of youth suicide proportionally, however, are among Native Americans, with the lowest rates tending to be among Asian/Pacific Islanders (Mazza, 2006).

Gender

Gender appears to have a stronger influence on youth suicidal behavior than ethnicity. Research has consistently found a strong but paradoxical relationship between gender and suicidal behavior (Miller & Eckert, 2009). Specifically, although adolescent females report much higher rates of suicidal ideation than adolescent males and attempt suicide at rates two to three times the rate of males, males die by suicide at a rate five times more often than females (Berman et al., 2006). Plausible reasons for the much higher suicide rate among young males in comparison to females include the higher rates of significant suicide risk factors among males (e.g., access to firearms, alcohol abuse) as well as their being less likely than females to engage in a number of protective behaviors, such as seeking help, being adequately aware of warning signs, having flexible coping skills, and developing effective social support systems (Miller, 2011).

Age

The probability of suicide increases in both males and females as children grow older. For example, adolescents who are 15 years of age and older are at much higher risk for suicide than youth ages 10 to 14, who are at higher risk for suicide than younger children under the age of 10 (Berman et al., 2006). Suicide does occur in children under the age of 10, and there have even been some documented cases of suicidal behavior in preschool children (Rosenthal & Rosenthal, 1984). In general, however, suicide among children below the age of 10 is extremely rare, with typically only a few reported cases each year. When suicide at this age level does occur, it is typically associated with severe dysfunction and psychopathology in the child’s family system (Miller, 2011).
Sexual Orientation

There is emerging evidence suggesting that gay, lesbian, bisexual, and transgendered (GLBT) youth may be at elevated risk for suicidal behavior in comparison to their heterosexual peers (Jacob, 2009). For example, based on data from the National Longitudinal Study of Adolescent Health, a recent study found that GLBT youth were much more likely to report suicidal ideation (17.2% vs. 6.3%) and attempt suicide (4.9% vs. 1.6%) than non-GLB youth (Silenzio, Pena, Duberstein, Cerel, & Knox, 2007). However, data specifically linking suicide deaths to a homosexual orientation are currently lacking (Berman et al., 2006). In general, having a sexual minority status, including individuals who are gay, lesbian, bisexual, or transgender, may put an individual at increased risk for suicidal behavior, particularly suicidal ideation or suicide attempts.

Geography

As with adults, youth suicide rates are highest in the western states and Alaska and lowest in the northeastern states (Berman et al., 2006). The sparser population, greater physical isolation, fewer mental health facilities, and limited opportunities for social interaction that characterize many western states may lead to greater social disconnection, a variable highly associated with suicide (Joiner, 2005). Consistent with this hypothesis is the finding that suicide rates are typically higher in rural areas than in urban areas (Berman et al., 2006).

Socioeconomic Status

Research regarding the influence of socioeconomic status (SES) and suicidal behavior has been described as “mixed and contradictory” (Berman et al., 2006, p. 31). Although suicide occurs across all socioeconomic levels, research generally suggests that there is an inverse relationship between SES and suicide rates in both the United States and other countries (Stack, 2000; Ying & Chang, 2009). Research on SES and youth suicide is lacking, although one study examining the socioeconomic differences among more than 20,000 Danish youth who died by suicide found that individuals in the lowest socioeconomic quartile had more than five times the risk of suicide compared to their more affluent peers (Qin, Agerbo, & Mortenson, 2003).

Risk Factors

Variables that help explain or predict youth suicidal behavior can be placed into two broad categories: risk factors that may predispose an individual to suicidal behavior, and warning signs that may indicate the possibility of a suicidal crisis (Van Orden, Witte, Selby, Bender, & Joiner, 2008). Risk factors suggest a more distant temporal relationship to suicidal behavior, whereas warning signs suggest a more proximal relationship (Van Orden et al., 2008). Although numerous risk factors for suicide have been identified, the two most prominent are (a) the presence of at least one mental health disorder; and (b) a history of previous suicidal behavior, particularly suicide attempts. Both of these risk factors are discussed in greater detail below, followed by a brief overview of other risk factors for youth suicidal behavior.

Presence of Mental Health Disorders

The most reliable and robust risk factor for youth suicide is the presence of one or more mental health disorders. Findings from “psychological autopsies” (i.e., a systematic collection of data via structured interviews of family members and/or friends of the suicide victim) estimate that...
approximately 90% of youth who die by suicide experienced at least one mental disorder at the time of their deaths (Berman et al. 2006; Shaffer et al., 1996). The most common mental disorders exhibited by youth who die by suicide are mood disorders (e.g., Major Depressive Disorder; Dysthymic Disorder; Bipolar Disorder), substance-related disorders (e.g., alcohol and/or drug abuse), and disruptive behavior disorders (Fleischmann, Bertolote, Belfer, & Beautrais, 2005), respectively. Although the large majority of clinically depressed youth are not suicidal and not all, suicidal youth are clinically depressed (Reynolds & Mazza, 1994); approximately 42% to 66% of youth who die by suicide appear to have been experiencing some type of depressive disorder at the time of their deaths (Fleischmann et al., 2005; Shaffer et al., 1996).

Other mental disorders that have been linked to youth suicide include anxiety disorders (e.g., Panic Disorder; Posttraumatic Stress Disorder), Schizophrenia, Borderline Personality Disorder, and Adjustment Disorder. The eating disorders of Anorexia Nervosa and Bulimia are also known to confer risk for suicide. However, although both Anorexia and Bulimia increase risk of suicidal ideation and suicide attempts, only Anorexia is associated with an increased risk for death by suicide (Mazza, 2006; Miller, 2011). Most youth who die by suicide have comorbid psychiatric disorders, which often makes assessment and treatment of these individuals especially challenging.

Other variables associated with youth suicide include hopelessness, sexual and/or physical abuse, self-injury, and peer victimization and bullying (Cleary, 2000; Klomeck, Marrocco, Kleinman, Schonfeld, & Gould, 2007). This last risk factor has important implications for both self-directed and outer-directed youth violence. For example, in the early 1980s, three suicides in Norway were linked to youth being bullied, which led the Norwegian government to develop a national campaign to investigate bullying and victimization problems (Espelage & Swearer, 2010). In the United States, recent cases of cyberbullying followed by the occurrence of youth suicides among some bullying victims have received substantial media attention. Further, an investigation conducted by the Secret Service revealed that among 37 incidents of school shootings and school attacks between 1974 and 2000, 71% of the perpetrators had been victims of bullying (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002).

**Previous Suicidal Behavior**

In addition to psychopathology, the other prominent risk factor for suicide is previous suicidal behavior, particularly previous suicide attempts. A general principle that applies to all behavior, including suicidal behavior, is that the best predictor of future behavior is past behavior. Consequently, the single best predictor of a future suicide attempt is a history of one or more previous suicide attempts.

**Other Risk Factors**

Children and adolescents who exhibit milder forms of suicidal behavior (e.g., suicidal ideation) but who are undertreated or not treated for it (e.g., not receiving antidepressant medication or psychotherapy) are at increased risk for suicide. Ethnic minority youth in the United States may also be affected by various risk factors that European American youth may not face, such as racial discrimination, acculturative stress, a fatalistic philosophy, and passive coping strategies (Gutierrez & Osman, 2008). Exposure to suicide through death of a peer also may be considered an accelerating risk factor, particularly among those already predisposed to be at risk (Berman et al., 2006). Some additional risk factors for youth suicide that have been identified include biological deficits in serotonin functioning, social isolation, limited access to mental health facilities, poor problem-solving and coping skills, low self-esteem, dysfunctional parenting or family environ-
ments, parental psychopathology, cultural or religious beliefs, access to lethal weapons, (particularly firearms), and repeated engagement in or exposure to violence (Joiner, 2005; Lieberman et al., 2008; Miller, 2011).

**Possible Warning Signs of Suicidal Behavior**

As opposed to risk factors, possible warning signs of suicidal behavior are more dynamic and proximal factors that suggest the increased probability of a suicidal crisis (Van Orden et al., 2008). A working group convened by the American Association of Suicidology (AAS) reviewed the research literature and reached consensus on a set of possible warning signs for suicide (Rudd et al., 2006). These warning signs, which should be shared with all students and school personnel, include (a) hopelessness; (b) rage, anger, seeking revenge; (c) acting reckless or engaging in risky activities, seemingly without thinking; (d) feeling trapped, as if there is no way out; (e) increasing alcohol or drug use; (f) withdrawing from friends, family, or society; (g) experiencing anxiety and/or agitation; (h) being unable to sleep or sleeping excessively; (i) dramatic mood changes; and (j) perceiving no reason for living or no sense of purpose in life.

A few caveats regarding warning signs should be noted. First, many of the currently known warning signs have not been validated specifically for youth suicide. More research is needed to determine if signs of acute suicide risk differ between children, adolescents, and adults (Van Orden et al., 2008). Second, although the giving away of possessions has frequently been described as a warning sign for suicide, there is no empirical evidence to support this contention, so it is not listed above as a warning sign. Third, and perhaps most important, many if not most youth exhibit some or even several of these warning signs and never engage in suicidal behavior, and it is not clear how many of these warning signs, or what combination of them, are the best predictors of suicide (Miller, 2011). Nevertheless, youth who exhibit several warning signs in addition to one or more of the risk factors described above should be viewed as being at high risk for suicide, and should be individually assessed by an appropriate school-based mental health professional.

**Situational Crises, Stressful Life Events, and Precipitants**

Risk for suicidal behavior increases when acute situational crises or stressful life events (e.g., some type of loss of an interpersonal nature) occur in conjunction with other, more chronic risk factors, such as depression, substance abuse, and/or access to lethal methods (Lieberman et al., 2008). Several different types of stressful events that may precipitate suicidal behavior in youth have been identified, including a relationship breakup, parental divorce, and school failure. Although these events do not directly cause suicidal behavior, they may have the potential to “trigger” suicidal behavior in potentially vulnerable youth (Miller, 2011). No one particular stressful event is highly predictive of suicidal behavior, although the risk for suicide increases as the number and emotional intensity of stressful events increase in the lives of children and adolescents already predisposed to suicidal tendencies (Miller & McConaughy, 2005).

**Protective Factors**

The finding that many youth who have a number of prominent risk factors for suicide do not engage in suicidal behavior suggests the presence of various protective or resiliency factors. Protective factors refer to those variables that have been linked empirically (e.g., as mediators or moderators) to decreased risk for suicidal behavior (Gutierrez & Osman, 2008). Although work in this area is increasing, less research has been devoted to examining protective factors.
in comparison to risk factors in regards to suicide, and as a result relatively little is known about which factors might mitigate risk factors for suicidal behavior (Berman et al., 2006). Some protective factors that have been tentatively identified, however, include (a) social problem solving and coping skills; (b) self-esteem; and (c) social support, both from peers and (particularly) parents (Miller, 2011). In addition, although not specific to suicide, a number of other protective factors have been identified that can often offset other risk factors. These include close peer friendships, high self-efficacy, and caring and responsive school personnel (Miller, 2011).

Suicide “Contagion”

An important issue for school personnel is the possibility of suicide “contagion.” This concern developed from research which suggested that suicide can be “contagious,” in the sense that exposure to suicidal behaviors—either through personal experience or media exposure—can influence others to copy them (Berman et al., 2006). In regards to suicide contagion and the media, research suggests that the influence is modest, although the media can play an important role in the decision-making processes of vulnerable youth. Given that children and adolescents may be especially vulnerable to media influences, providing guidelines to the media about the accurate and appropriate portrayal of suicide is very important (Miller, 2011).

Suicide and Homicide: Youth Suicidal Behavior and School Shootings

Suicide and violence prevention efforts have generally occurred in relative isolation from one another (Lubell & Vetter, 2006), although recent tragic events have highlighted the occasional relationship between suicidal behavior and violent behavior toward others, particularly in the context of school shootings (Nickerson & Slater, 2009). For example, the U.S. Secret Service and U.S. Department of Education’s study of school shootings found that 78% of school shooters exhibited suicidal ideation to a significant degree (Vossekuil et al., 2002). When considering this issue, however, it should first be clearly understood that school shootings are extremely rare events. In fact, students are safer in schools than in most any other place they could be, and the odds of a student being injured or killed as a result of a school shooting is literally millions to one. Nevertheless, the numerous multiple-victim shootings that occurred during the late 1990s, particularly the 1999 school shootings at Columbine High School in Colorado, dramatically changed public opinion about the safety of America’s schools (Van Dyke & Schroeder, 2006).

The extensive media coverage given to school shootings has made this a topic of intense interest in the United States, particularly among parents, policy makers, and school administrators. Although there have been attempts to “profile” school shooters for purposes of identification and prediction, the FBI has cautioned against the use of student profiling to identify potential school shooters (Cornell & Williams, 2006). Instead, the FBI has recommended that schools adopt a threat assessment approach, which is consistent with subsequent recommendations made by both the Secret Service and the Department of Education (Fein et al., 2002; National Institute of Justice, 2002). Some common characteristics of school shooters have been identified, including (a) being male, (b) having a history of peer mistreatment and bullying, (c) demonstrating a preoccupation with violent games and fantasies, and (d) exhibiting symptoms of depression and suicidality (Fein et al., 2002; National Institute of Justice, 2002). Unfortunately, a listing of these characteristics is not particularly helpful because it does not provide sufficient specificity for practical use—far too many students would be falsely identified as potentially violent (Sewell & Mendelsohn, 2000). As with predicting precisely which students are most likely to engage in suicidal behavior (Pokorny, 1992), predicting which students will engage in school violence (e.g., school shootings) based on particular risk factors has inherent
limitations (Mulvey & Cauffman, 2001) because both are low base-rate behaviors. However, although school personnel cannot predict with complete accuracy which students will become school shooters any more than they can predict which students will attempt or die by suicide, they can determine periods of heightened risk for both.

For example, the most promising finding from the FBI’s study of school shootings was that the student perpetrators almost always made threats or communicated their intentions to harm someone before the shooting occurred (Cornell & Williams, 2006). Further, the FBI identified a number of cases where school shootings were prevented because authorities investigated a student’s threatening statement and found that the student was engaged in plans to carry out the threat. These observations are similar to findings from youth who engage in suicidal behavior, who likewise frequently communicate their suicidal intent, most typically to peers (Miller, 2011). This suggests that schools should focus their efforts on the identification and investigation of student threats (whether suicidal or homicidal) rather than on the presence of particular risk factors.

It is critical that the above discussion of youth suicide and homicide be viewed in appropriate perspective. The overwhelming majority of youth who engage in suicidal behavior do not engage in homicidal behavior, either at school or outside of it. This is true for adults as well. For example, murder-suicides account for only about 1.5% of all annual suicides in the United States (Holinger, Offer, Barter, & Bell, 1994). That said, there does appear to be a relationship between suicidal behavior and other forms of violence. For example, a study involving over 11,000 students who completed the Youth Risk Behavior Survey in 2005 revealed that predictors of suicidal behavior for both male and female adolescents included carrying a weapon, being threatened or injured at school, having property stolen or damaged at school, and getting in a fight (Nickerson & Slater, 2009).

Table 17.1 Implications for Practice

1. Youth suicide is major public health problem that requires urgent attention. As children and adolescents spend much of their time in school, educational facilities provide ideal locations for focused prevention efforts.

2. Although school personnel do not usually associate school violence with self-directed violence, youth suicidal behavior in schools, particularly suicidal ideation, suicide-related communication, and suicide attempts, can and does occur in schools, and school personnel need to be cognizant of the various risk factors and warning signs of suicidal behavior, as well as the demographic variables that surround youth suicide.

3. The two most prominent risk factors for suicide are the presence of mental health problems, typically depression, and a history of previous suicidal behavior. This information should be communicated annually to all students and school personnel, particularly at middle and high schools where the probability of youth suicidal behavior is highest.

4. There are a number of warning signs of potential suicidal behavior, and all students and school personnel should be trained to recognize them. Students and school personnel also need to know what to do and who to report to when they suspect a particular student may be suicidal. All schools should have written policies and procedures in regards to youth suicide, and school personnel should routinely receive training in these policies and procedures.

5. A comprehensive, public health approach is recommended for the school-based prevention, assessment, and intervention with potentially suicidal youth.

6. Student suicide and homicide is an extremely rare occurrence, but school personnel should be prepared for this possibility. School-based mental health professionals should be equally skilled in conducting suicide risk assessments and student threat assessments.

7. Predicting precisely which students will be suicidal, like predicting which particular students will engage in extreme forms of school violence (e.g., school shootings), is inherently difficult. However, school personnel can and should be trained to assess for heightened risk for both.
Consequently, when youth are suspected of engaging in or being capable of violence toward others or of suicidal behavior, it would be prudent to conduct both a school-based threat assessment as well as a suicide risk assessment. Moreover, a comprehensive, school-based, public health approach to both suicidal behavior (Miller, 2011; Miller et al., 2009) and school violence (Espelage & Swearer, 2010; Furlong, Jones, Lilles, & Derzon, 2010), involving multiple levels of prevention and intervention to meet individual student needs, is increasingly viewed as the most appropriate and effective response to these problems. Although historically school-based suicide and violence prevention efforts have occurred in relative isolation from each other (Nickerson & Slater, 2009), there is no reason that this need be the case.

Conclusion

Youth suicidal behavior is a major public health problem that affects thousands of children and adolescents, as well as their friends and families, each year. Despite its widespread occurrence, youth suicidal behavior has to date not received significant attention in the school violence literature. This situation will hopefully be changing, particularly given the documented relationship between suicide and other forms of school violence, including bullying, peer victimization, and school shootings. Although space limitations prohibit a more extensive discussion of this topic, readers interested in gaining additional information on the school-based prevention, assessment, and treatment of youth suicidal behavior are referred to other sources, especially Gutierrez and Osman (2008), Lieberman et al. (2008), and Miller (2011).

References


