MORE THAN SAD

Suicide Prevention Education for Teachers and Other School Personnel

Participant Program Manual

AMERICAN FOUNDATION FOR Suicide Prevention

The American Foundation for Suicide Prevention (AFSP) developed this educational program to help increase teachers' knowledge and understanding of suicidal behavior in youth — its causes, treatment and prevention. Equipped with such knowledge, it is our hope that teachers will be better prepared to identify and refer students who may be at risk for suicide.

PROGRAM MATERIALS

- This Manual
- *More Than Sad: Preventing Teen Suicide* film
- *More Than Sad: Teen Depression* film
- Standardized PowerPoint

Updated in 2015, this program has been designed to comply with the requirements for teacher education in suicide prevention now in effect in many states. The program can also be used as part of ongoing in-service training related to student mental health. Although it is especially addressed to teachers, the material is relevant and helpful for all school personnel whose work brings them in contact with students, including school nurses, psychologists, social workers, counselors, school resource officers and administrators. Depending on the circumstances and requirements of a particular school district or other organization, the program can bused as a curriculum for a group in-service or training. It may also be appropriate for use by those who work with and care for adolescents outside of school settings.

THE GOALS ARE

1. To increase understanding of the problem of youth suicide, the risk factors that can lead to suicide, and the treatment and prevention of suicidal behavior in adolescents.
2. To increase knowledge of the warning signs of youth suicide, so that teachers and other adults who work with teens are better prepared to identify and refer students who may be at risk.

WHAT TOPICS WILL BE ADDRESSED?

- How Big of a Problem is Youth Suicide?
- How Can Teachers Help Prevent Youth Suicide? (Includes film.)
- What Puts Teens at Risk for Suicide?
- What Treatments are Available?
- How Can Teachers Identify At-Risk Students? (Includes film.)
- How Else Can Schools Decrease Risk?

Thank you for taking this opportunity to learn more about teen suicide and how you can play a role in its prevention.

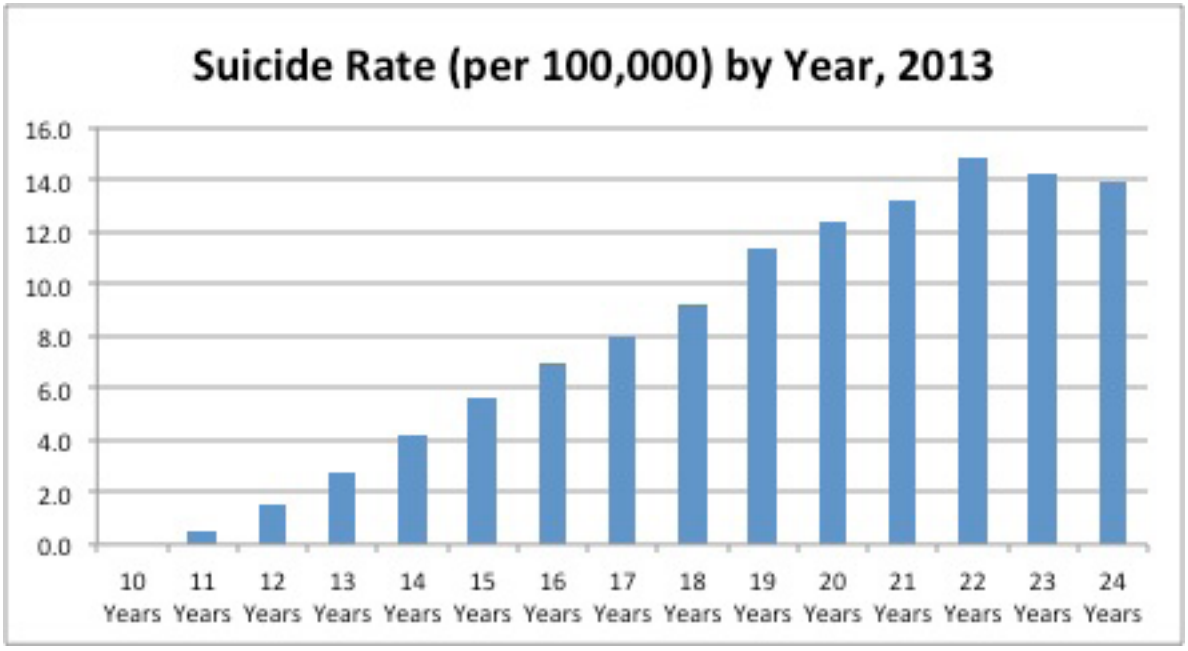
How Big of a Problem is Youth Suicide?

SUICIDE DEATHS

Youth suicide is a leading cause of death for youth in the United States.
While suicide deaths before the age of 11 are rare, beginning around the time of puberty, the frequency of suicide increases dramatically with age until the early 20s.

The frequency of suicide is measured as a "rate," which is defined as the number of suicides that occur in a particular group of people for every 100,000 persons in that group. It should be noted that official suicide statistics include only those deaths that can be conclusively determined to have resulted from an act of self-harm. Because many suicides are classified as accidents or as resulting from an undetermined cause, official suicide rates almost certainly underestimate the extent of the problem.

Figure 1 below shows suicide rates for youth in the United States for various ages, ranging from age 10 to 24. These figures are for 2013, the latest year for which suicide statistics are currently available.



Approximately 5,200 young people under the age of 25 are reported to die by suicide each year. That's over 100 deaths each week. Suicide is the second leading cause of death for adolescents and young adults, following unintentional injuries.

While the overall youth suicide rate remains unacceptably high, rates for adolescents aged 15 – 24 have declined since the mid-1990s, as shown in **Figure 2**.

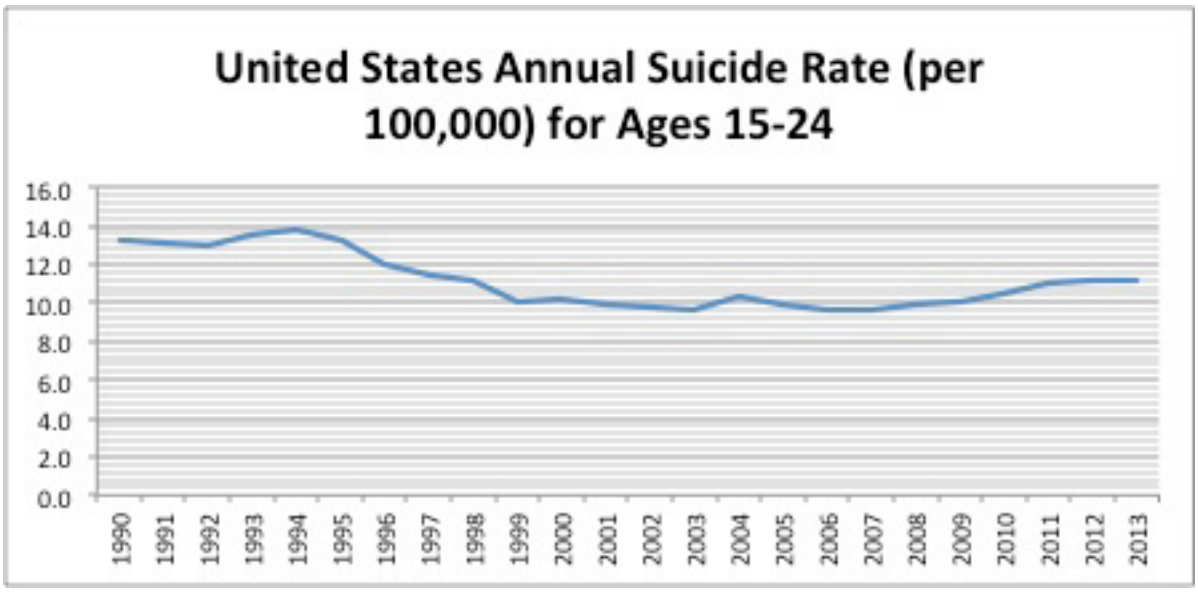
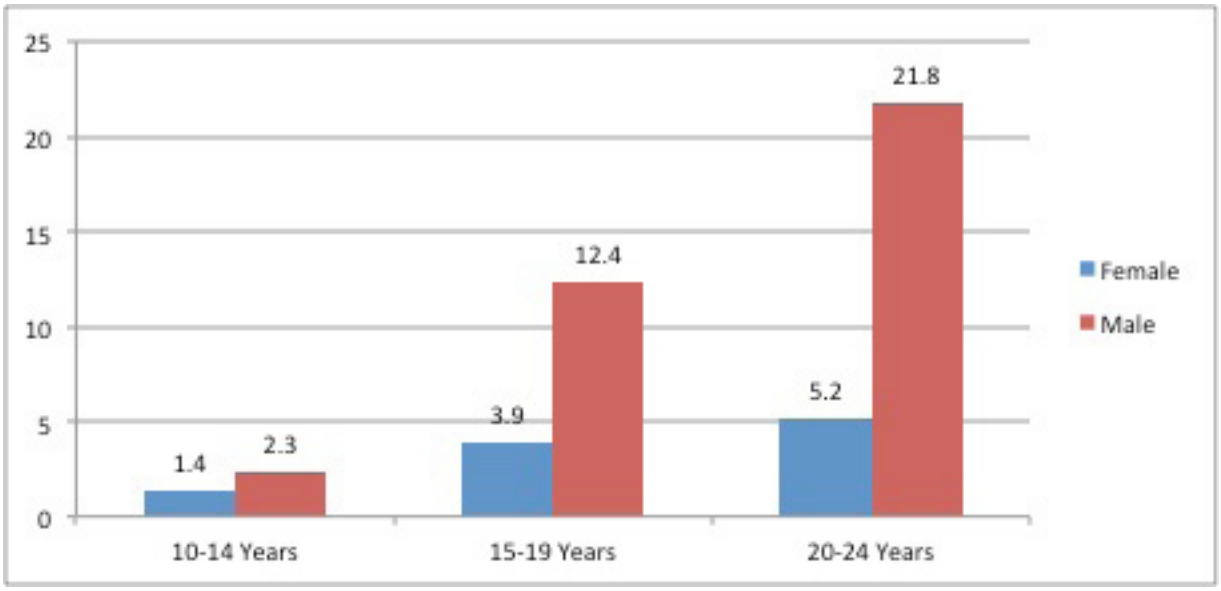
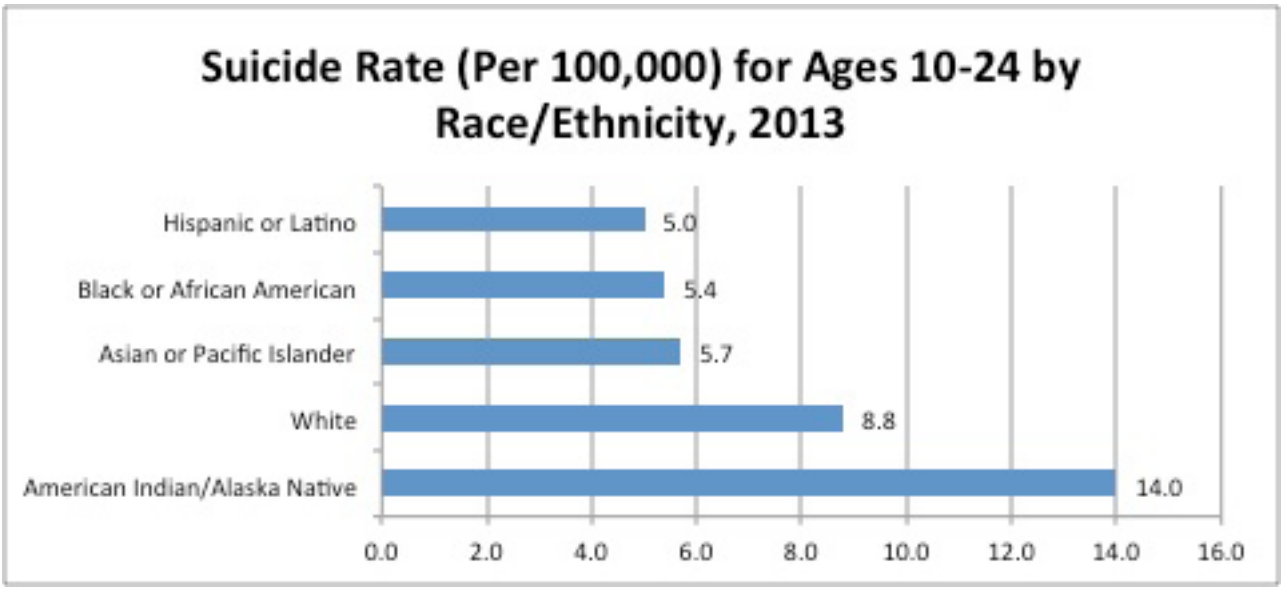


Figure 3 shows the gender differences in suicide rates for three age groups: 10-14, 15-19 and 20-24. Consistently, the suicide rate for boys is much higher than that for girls of the same age.



Youth suicide rates also vary by ethnicity. As seen in **Figure 4**, American Indian and Alaskan Native youth ages 10-24 currently have the highest suicide rate, with 14.0 suicides for every 100,000 young people in these groups. White youth in the same age range have a rate of 8.8 per 100,000, while Asian/Pacific Islander, Hispanic and Black youth have still lower suicide rates than these other groups.



SUICIDE ATTEMPTS

While suicide death is the most tragic outcome of suicidal behavior, suicide attempts also exact an enormous toll among the affected individuals, their families, friends and communities. For the United States, there is no official count of the frequency of suicide attempts, and it is certain that the numbers reported by hospitals and other sources underestimate the number of suicide attempts that actually occur.

For every 10–14 year-old who dies by suicide, there are estimated to be approximately 200 medically serious suicide attempts. The ratio of suicide attempts to suicide deaths among 15–19 year-olds is about 100:1 and among 20–24 year-olds, it is about 65:1. The number of suicide attempts for each suicide death generally continues to decline throughout the life cycle. Among persons over the age of 70, for example, there are estimated to be four serious suicide attempts for each suicide death.

One of the most commonly used sources of information about teen suicide attempts is the Youth Risk Behavior Survey (YRBS), a national survey of students in grades 9 through 12 which is conducted every two years by the Centers for Disease Control and Prevention (CDC). Along with questions about use of alcohol and drugs and other risky behaviors, the YRBS asks students about suicidal behavior. Findings from the 2013 survey show that:

- More than 1 in 12 students who completed the survey reported having attempted suicide during the past year, and
- Nearly 1 in 36 students reported receiving medical attention for a suicide attempt in the past year.

The data from this survey consistently show that adolescent girls report roughly twice as many suicide attempts as boys, even though boys die by suicide much more frequently than girls. Girls' higher rates of self-reported suicide attempts are generally confirmed by reports from hospital emergency rooms. The higher rate of completed suicide among boys is in part due to their much greater use of highly lethal methods, such as firearms.

SUICIDAL IDEATION

The term "suicidal ideation" refers to thinking about or planning for suicide. The Youth Risk Behavior Survey asks students about whether they have had thoughts about suicide or have made a suicide plan in the past year. Recent results also indicate that:

- 17 % of high school students seriously considered suicide in the past year, and
- 13.6 % of high school students made a suicide plan.

UPDATES ON FIGURES

An excellent source of suicide-related data is the website of the Centers for Disease Control and Prevention, www.cdc.gov. Particularly helpful sections of this website are the Injury Statistics Query and Reporting System (www.cdc.gov/injury/wisqars/) and the Youth Risk Behavior Survey (www.cdc.gov/HealthyYouth/yrbs/). The CDC updates this information on a regular basis so that the latest available figures can be easily accessed.

How Can Teachers Help Prevent Youth Suicide?

Because adolescents spend such a large part of their day in school, teachers, school nurses, psychologists, social workers, counselors, school resource officers and other personnel who interact regularly with students are in an ideal position to identify those who may be at risk for suicide — provided, of course, that they know what to look for. The identification and referral of at-risk students for a mental health assessment and evaluation can be the first step in helping these students overcome a possible debilitating and even life-threatening illness.

THE TEACHER'S ROLE

It is important to remember that it is not the teacher's responsibility to counsel at-risk students but merely to identify and to refer these students to the appropriate helping resource, as directed by the school's policy or protocol. Most often, schools instruct teachers to relay concerns about individual students to a counselor, a school nurse or another support person in the school. In some cases, teachers may be encouraged to talk directly to a student's parent or guardian about changes in behavior that may suggest a problem. As part of this educational program, we urge all teachers and other personnel to obtain a copy of their school's policy or protocol for referring students deemed to need mental health services, and make sure that they understand the recommended procedures.

What Puts Teens at Risk for Suicide?

Suicide is a complex behavior that is usually the result of multiple interacting factors, the most significant of which are mental health conditions. Studies show that 90% of people who die by suicide have a mental health condition. In many cases, however, the disorder had not been diagnosed or effectively treated prior to the suicide.

In this section, we review the key mental health conditions associated with youth suicide. For each mental health disorder, we present the major symptoms, discuss specifics of the disorder as it occurs in teens, and identify how the disorder contributes to suicide risk. Understanding these mental health disorders can help adults who work with teens more readily identify students whose behavior suggests they may be suffering from a condition that can lead to suicide.

Mental health conditions discussed are:

- Major Depressive Disorder
- Bipolar Disorder
- Generalized Anxiety Disorder
- Substance Use Disorders
- Conduct Disorder
- Eating Disorders
- Schizophrenia

At the end of this section, we discuss other individual and situational factors that increase suicide risk, and identify specific behaviors that may be warning signs for suicide.

ONE OR MORE MENTAL HEALTH DISORDERS MAY OCCUR TOGETHER

Each mental health disorder has its own criteria, or key symptoms that lead mental health professionals to make the diagnosis. Common among teens, however, there may be considerable overlap among the various disorders we will discuss. The term "comorbidity" is sometimes used to describe the occurrence of other disorders that are present in addition to a primary disorder. As a general rule, the presence of comorbid mental health disorders increases suicide risk substantially, and thus, particular attention should be paid to teens who exhibit symptoms of more than one of the disorders discussed.

MAJOR DEPRESSIVE DISORDER

Major Depressive Disorder (MDD) is commonly referred to as "major depression" or simply, "depression." The key symptoms of the disorder in children are listed below. In someone with major depression, a number of these symptoms persist day in and day out over a period of at least two weeks, and represent a noticeable change from the person's previous functioning. These symptoms cause distress or impairment in social, school or other important areas of functioning.

- Sad, depressed or hopeless mood, or irritable mood
- Markedly diminished interest or pleasure in all or almost all activities the person used to enjoy
- Significant weight loss or weight gain (change of more than 5% of body weight in a month), an decrease or increase in appetite, or failure to make expected weight gain
- Trouble sleeping or sleeping too much
- Moving or speaking very slowly, or the opposite — moving or speaking very quickly or in an agitated manner
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think, concentrate or make decisions
- Recurrent thoughts of death or suicide, making a specific plan for suicide, or making a suicide attempt

Major depression is a common mental health disorder affecting over 18 million people in the United States across all gender, age, racial and socioeconomic groups. In recent years, the age of onset of depression has become steadily younger, and the disorder is now surprisingly common among adolescents. During a given school year, it is estimated that 2.6 million adolescents will have depression. Adolescent girls are more likely than boys to be diagnosed with depression, possibly as a result of hormonal differences that become marked around the time of puberty. Through most of the lifecycle, women continue to have higher rates of depression than men, for reasons that are not yet well understood.

Some of the symptoms of depression may be evident during the normal "ups and downs" of adolescence, and sometimes parents and teachers find it difficult to distinguish these short-lived moods from depression. In general, depression is likely to be present when the following conditions are met:

- The symptoms last at least two weeks without a break
- There is a clear change from the adolescent's normal mood or behavior
- The symptoms are observed in several different contexts — at home, at school or work, with friends — suggesting they are not just a reaction to a specific problem

Studies have shown that chemical changes occurring in the brain are the major cause of depression. Researchers can see and examine these changes using sophisticated images taken of the brains of depressed people. Changes in brain chemistry can result from stressful events such as abuse or severe conflict within the family, rejection or other problems in peer or romantic relationships, school failures, a significant separation or loss, or serious problems with the law. But sometimes the chemical changes occur without any apparent reason, perhaps related to the presence of certain genes that can be passed down in families. So, just as people sometimes develop other illnesses with no clear cause outside their own bodies, people can become depressed even when nothing extraordinarily stressful or upsetting has happened to them.

Because depression is a "brain illness" that can be triggered by something inside the person, and not just a reaction to difficult or painful life circumstances, teachers and school personnel should keep in mind that it may not matter what a student's life looks like from the outside. Depression can develop in any adolescent, even those who seem to "have it all"— success in school or sports, involved and supportive parents and popularity among friends.

Depressed teens may have a particularly hard time understanding and talking about what they are experiencing, and may work hard at hiding their feelings. Sometimes, they may express their pain through themes of death or hopelessness in their artwork, poetry, short stories or essays. These can provide openings to talk to students about what they may be feeling.

Other times, depression in teens may be expressed through physical complaints, such as frequent stomach distress or headaches. It's important to remember that young people often are not able to put their feelings into words and may associate the sense of low energy and "malaise" that accompanies depression with feeling physically sick.

Several different rating scales have been developed to help identify depression and measure its severity. Some of these measures are designed specifically for adolescents, and include questions about common symptoms of depression that teens can answer and sometimes even score by themselves. It is not recommended that teens be

asked to complete a screening measure in a classroom or other group setting where a clinically trained person is not available to provide follow-up evaluation and referral to treatment, as needed. Also, individual assessment of depression in youth under the age of 18 may require consent from a parent or guardian, depending on state laws.

Major depression is the mental health disorder most frequently associated with suicide in both teens and adults. Perhaps because depression is so common, symptoms may be overlooked or attributed to a phase that someone is going through rather than as signs of a potentially fatal illness.

BIPOLAR DISORDER

Like major depression, bipolar disorder (sometimes referred to as "manic-depression") is a mood disorder. In contrast to the "down" feelings that come with depression, in bipolar disorder episodes alternate between depression and mania (or feeling really "up"). Individuals diagnosed with bipolar disorder have manic symptoms (as listed below) for a period of at least one week. This may be preceded by one or more episodes of depression, with the symptoms that have already been discussed.

Symptoms of mania include:

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Talking much more than usual or pressure to keep talking
- Flight of ideas or jumping from one thought to another
- Distractibility or inability to keep attention on the task at hand
- Increased goal-directed activity or engaging in more activity in an agitated manner
- Excessive involvement in activities having high potential for painful consequences, such as unrestrained buying sprees or indiscriminant sexual encounters

There are many variations in the way bipolar disorder manifests. The depressive and the manic phases of the disorder may last for several weeks at a time, or the person's mood may shift quickly back and forth between the two states. Manic symptoms may cause significant social, academic or work impairment, and can be so severe that the person appears to have lost touch with reality. In some cases, manic symptoms are less severe or impairing and more aptly described as "hypomanic.

Common manic symptoms in teens with bipolar disorder include working at a fever pitch, talking too fast or too loudly, being exceptionally fidgety or unable to sit still, dressing in provocative clothing, engaging in risky sexual behavior or behaving in other ways that seem "out of control." In most cases, bipolar disorder leads to significant problems in school, work and relationships.

Although bipolar disorder is less common than depression in both teens and adults, those with the illness are at particular risk for suicide. Almost always, the suicide of a person with bipolar disorder occurs during the period when depressive rather than manic symptoms are present. Risk appears greatest in individuals who experience rapid "cycling" of manic and depressive episodes, or have "mixed" episodes in which depressive and manic symptoms are present at the same time.

About one-third of people diagnosed with bipolar disorder experience their first episode during the teen years. Depressive symptoms are more common than manic symptoms in the first episode, which results in some teens being misdiagnosed. Unlike depression, bipolar disorder is as likely to occur in boys as it is in girls.

GENERALIZED ANXIETY DISORDER

Generalized Anxiety Disorder (GAD) is characterized by excessive and uncontrolled anxiety and worry about a number of events or activities (such as school or work performance). Symptoms occur more days than not for a period of at least six months, and cause significant distress or impairment in social, academic or other important areas of functioning.

Symptoms of GAD include:

- Restlessness, feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbances, including difficulty falling or staying asleep, or restless, unsatisfying sleep

GAD may affect any teen, but young people who are "perfectionists" or feel that others expect them to always excel may be especially vulnerable. And because many high-achieving teens may be unaccustomed to experiencing difficult situations, it may be particularly hard for them to admit that they need help. Girls are more likely than boys to have GAD.

In addition to GAD, there are several other anxiety disorders that may affect adolescents, including social anxiety disorder (also referred to as social phobia), obsessive-compulsive disorder and panic disorder.

Each of these disorders has its own set of specific symptoms, but the common thread among all anxiety disorders is an anxious, fearful mood that leads to additional symptoms and disability.

Severe anxiety is often part of depression in teens. Sometimes an increased and excessive worry about things such as tests and school assignments or social situations is the first sign that something is wrong. Feeling so nervous, anxious or stressed out can lead to other symptoms of depression — trouble sleeping, difficulty concentrating, loss of appetite and feeling really down.

Like depression, anxiety is commonly expressed in teens through physical symptoms, such as feeling like one's heart is racing or experiencing shortness of breath. Many teens may not recognize these symptoms as signs of a mental, rather than a physical, disorder.

Posttraumatic stress disorder can also affect adolescents who have been exposed to a serious injury, sexual violence or a life-threatening event.

Those who work with youth must be careful not to underestimate the seriousness of anxiety or posttraumatic stress disorder in adolescents. Whether co-occurring with depression or alone, the symptoms can sometimes become so overwhelming that youth feel they can't go on, and may begin thinking they would be better off dead.

SUBSTANCE USE DISORDERS

Substance use disorders involve a maladaptive pattern of drug or alcohol use that leads to significant impairment or distress. At least two or more of the following symptoms must be present, occurring at any time in the same 12-month period:

- Increasing tolerance of the substance (i.e., the need for increased amounts of the drug or alcohol to achieve the desired effect, or a markedly diminished effect with continued use of the same amount)
- Withdrawal effects when the substance is not used
- Taking the substance in larger amounts, or over a longer period, than intended
- Persistent desire or unsuccessful efforts to cut down use
- Spending considerable time obtaining the substance, using it or recovering from its effects
- Giving up or reducing important activities because of substance use
- Continued substance use despite knowing that it is causing a significant physical or psychological problem
- Failing to fulfill major role obligations at school, work or home because of recurrent substance use (e.g., repeated absences, suspensions or expulsions from school or poor school performance)
- Recurrent substance use in situations in which it is physically hazardous, such as driving a car
- Recurrent substance-related legal problems, such as arrests for drunk driving or disorderly conduct while drinking or using drugs
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance, such as arguments or physical fights

Substance use disorders can be mild, moderate or severe based on how many of the above symptoms are present.

Use of alcohol or recreational drugs is frequent among teens in most areas of the country, and contributes to a range of social, academic, psychological and legal problems. Many teens drink to be part of their peer group. Some drink to help them feel less stressed out, anxious or depressed, but since alcohol is a depressant, over time these problems are almost always worsened by drinking. Alcohol and some drugs can also increase irritability and anger, making it harder to get along with family and friends. Substance use can also make sleeping problems worse, which makes it harder to concentrate or cope with the stress of school or other activities. Engaging in under-age drinking can also lead to family conflict and problems with the law, eroding needed social support and compounding depression and anxiety.

Use of alcohol or drugs is a factor in a significant proportion of youth suicides. In addition to exacerbating other mental health conditions and thus increasing suicide risk, substance use may decrease inhibition, which can lead to an increase in impulsive, self-destructive behavior when under the influence even when no substance use disorder is present.

CONDUCT DISORDER

Conduct disorder is a repetitive and persistent pattern of behavior in children or adolescents, in which the basic rights of others or social norms and rules are violated, resulting in significant impairment in social or academic functioning. In order for a teen to be diagnosed with conduct disorder, he or she must exhibit at least three of the following symptoms, generally over a period of the last 12 months, with at least one symptom present in the last six months:

- Frequently bullying, threatening or intimidating others
- Frequently initiating physical fights
- Using a weapon that can cause serious physical harm
- Physical cruelty to people
- Physical cruelty to animals
- Mugging, shoplifting, stealing
- Forced sexual activity
- Fire setting with the intention of causing serious damage
- Deliberately destroying others' property
- Breaking into someone's house or car
- Lying or conning others to obtain goods or favors or avoid obligations
- Staying out all night without parental permission
- Running away from home
- Frequent truancy from school

Youth with conduct disorder are usually readily spotted in the school environment, where their anti-social behavior typically leads to their being disliked by peers and adults alike. Teachers and other school personnel generally find these teens to be rude, inattentive, uncooperative and non-responsive to normal requests, corrections or sanctions. These "bad" behaviors may signal a serious mental health disorder.

There is a strong genetic component to the aggressiveness seen in most teens with conduct disorder. Conduct disorder is much more prevalent in boys than in girls.

In addition, teens with conduct disorder have a high likelihood of also developing depression and substance use disorder, which in turn can increase anti-social behaviors and lead to further academic, disciplinary or legal problems. The consistently negative feedback such teens experience from those around them also contributes to their feeling depressed, isolated and hopeless.

Conduct disorder, combined with substance abuse disorder or depression is associated with particularly high rates of suicidal thoughts, suicide attempts, and completed suicide, especially when accompanied by one or more other mental health disorders.

EATING DISORDERS

Although eating disorders were not discussed in the film seen earlier in this educational program, we mention them here because, despite being less common than the other mental health conditions, they convey an especially high risk of suicide when associated with depression and/or substance use disorder. There are two main types of eating disorders: anorexia nervosa and bulimia nervosa. Both of these disorders primarily affect adolescent girls and young women.

Symptoms of anorexia nervosa include:

- Restriction of food intake leading to low body weight for one's gender and age
- Intense fear of gaining weight or being "fat" despite being underweight
- Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight

Symptoms of bulimia nervosa include:

- Recurrent episodes of binge eating (on average, at least twice a week for three months), in which an inordinate amount of food is eaten in a short period of time, together with the feeling that one cannot stop eating or control what or how much one is eating
- Recurrent inappropriate behaviors to compensate for binge eating and avoid gaining weight, such as self-induced vomiting, misuse of laxatives, fasting or excessive exercise
- Self-evaluation unduly influenced by body shape and weight

Eating disorders are far more common in females than in males, and typically begin between the ages of 13 and 20. If left untreated, the disorder generally increases in severity, peaking in early adulthood. Eating disorders are strongly linked to other mental health disorders, in particular depression and anxiety. Eating disorders present as mild, moderate, severe and extreme.

Between 10–20% of patients diagnosed with anorexia nervosa are estimated to die prematurely, many by suicide. Young women aged 15–24 with eating disorders co-morbid with depression and/or substance use are estimated to have a suicide rate almost 60 times the expected rate for young women overall.

SCHIZOPHRENIA

Another mental health disorder that deserves mention because of its strong link to suicide is schizophrenia. Schizophrenia is a "psychotic disorder" that causes people to have difficulty interpreting reality and relating to others. The symptoms of schizophrenia are divided into two sets, termed positive and negative, although both symptom sets are pathological or abnormal. Positive symptoms are those that distort normal function. Negative symptoms are those that cause a lessening or loss of normal function. To be diagnosed, positive symptoms must generally be present for at least one month, with negative symptoms present on a continuous basis for at least six months.

Positive symptoms of schizophrenia include:

- Delusions (beliefs that are held in spite of invalidating evidence, such as believing that other people are controlling one's thoughts or plotting to cause one harm)
- Hallucinations (sensory perceptions that are not occurring in reality, such as hearing voices, smelling odors or seeing things)
- Disorganized or incoherent speech
- Disorganized or "catatonic" behavior such as motor immobility or stupor

Negative symptoms include:

- Low energy or motivation
- Appearing to lack emotion
- Difficulty expressing thoughts or elaborating responses
- Social withdrawal, isolation, or a lack of interest in socializing

The illness affects both genders, and generally begins to develop during very late adolescence or early adulthood. Schizophrenia tends to have an earlier onset in men than in women, with initial symptoms typically emerging between the ages of 15 and 25. The disorder is strongly linked to genetic factors, and is not related to negative experiences, stress or alcohol or drug use, even though such events may precipitate onset.

People with schizophrenia have very high rates of suicidal behavior. It is estimated that 40% make at least one suicide attempt during the course of the illness, and 10% die by suicide. Fifteen percent of people who die by suicide are psychotic at the time of their death whether they have schizophrenia or a psychotic mood disorder.

OTHER INDIVIDUAL FACTORS THAT INCREASE SUICIDE RISK

Impulsive and aggressive behavior

Suicidal behavior in teens is frequently associated with impulsive or aggressive-impulsive behavior, particularly in the context of depression or bipolar disorder. Impulsivity has been found to be associated with dysregulated brain chemistry, and is thought by some researchers to help explain why some adolescents with depression and bipolar disorder engage in suicidal behavior while others do not.

Family History

As has already been suggested, a family history of mental illness contributes to the likelihood that a teen will develop a mental health disorder. Studies have identified genes for some mental health conditions, notably depression, that can be passed from a parent to a child. Exposure to parental mental health conditions during childhood and adolescence can also result in learned behaviors that may affect how a particular disorder is expressed in the teen. Genes are also related to the way people react to stress.

Suicide attempts and completed suicide are also more frequent in families in which a relative has attempted suicide or died by suicide. This may be due, in part, to the transmission of impulsivity from parents to children.

School personnel should be mindful of the possibility of mental health conditions in the family when communicating with the parents of a teen who may have a mental health disorder. Parents who themselves have been diagnosed and successfully treated for a mental health disorder may be quite open to hearing the school's concerns about behavioral changes in a son or daughter, but others may not. In all cases, it is essential to approach parents and family members in a sensitive, objective and non-judgmental way.

Prior suicide attempt

Risk for completed suicide is increased in youth who have made a prior suicide attempt. Studies have shown that 30–40% of adolescents who die by suicide have a history of one or more previous attempts.

Situational Factors that Increase Suicide Risk

Although an untreated or ineffectively treated mental health disorder is the single largest factor associated with suicide and suicide deaths, stressful life events may act as a trigger for suicidal behavior in some teens. Such events may include recurrent physical or sexual abuse; death of a parent or close relative; prolonged, serious family conflict; a traumatic break-up with a boyfriend or girlfriend; school failures or other major disappointments; and persistent bullying, harassment or victimization by peers.

In assessing the impact of stressful life events on teen suicide, it should be kept in mind that the large majority of youth who experience stressful life events do not become suicidal. In some teens, however, the normal feelings of sadness, grief or humiliation that result from upsetting life experiences can precipitate depression, anxiety or another mental health disorder, which in turn increases suicide risk. It should also be kept in mind that mental health concerns can precipitate stressful events, as in the case of school failures that result from an inability to concentrate due to depression or anxiety. Situational risk factors having particular relevance for schools include the following:

History of physical and sexual abuse

Childhood physical or sexual abuse is a common factor among adolescents who attempt or complete suicide. Studies that have controlled for the presence of other risk factors, such as individual or parental mental health conditions, have found that adolescents with a history of physical abuse are five times more likely to make a suicide attempt than those who have not been abused. Adolescents who have been sexually abused are more than seven times more likely to attempt suicide. Teachers and other school personnel who suspect that a student may have been abused should follow school policies for making a referral for appropriate evaluation and services, as needed.

Bullying

Studies in the U.S. and other countries indicate that bullying is common place in schools, with about 10% of adolescents aged 14–16 reporting being bullied on a weekly basis. Bullying may be either physical or verbal, and increasingly includes "cyber-bullying" that takes place over the internet.

Students who report being bullied, as well as those who admit to bullying others, have been found to have significantly higher rates of depression, suicidal ideation and suicidal behaviors than students who do not report experiences with bullying. These problems appear to be particularly likely to occur among youth who are both a victim and a perpetrator of bullying. Some studies have found suicidal ideation and behavior to be particularly frequent among female students who are involved in bullying, whether as a victim, a perpetrator or both.

In some teens, depression and/or other suicide risk factors may precede or lead to bullying. Preexisting risk may help to explain why some youth who are involved in bullying engage in suicidal behavior while others do not. In all cases, persistent bullying has a significant negative impact on the mental health of youth, and systematic interventions are needed to reduce bullying behavior in school, and treat mental health conditions.

Sexual orientation and gender identity

Many studies have found lesbian, gay, bisexual and transgender (LGBT) youth to have elevated rates of depression, and more frequent reports of suicidal ideation and behavior, compared to youth who describe themselves as heterosexual or "straight." Depression in LGBT youth is associated in particular with family rejection because of sexual orientation or gender identity, high rates of alcohol or drug use, and social ostracism and bullying by peers.

A number of studies in the U.S. and abroad have found an association between reported suicidal behavior in LGBT adolescents and school-based bullying, harassment or violence because of sexual orientation. The frequency of bullying or victimization appears to be increased in youth who show gender-variant behaviors or are recognized or perceived as LGBT during childhood or early adolescence.

Trouble with the law

Studies have shown that teens that have a history of problems with the law are at increased risk for both attempted and completed suicide.

In adolescents, legal problems commonly overlap with a range of other problem behaviors such as school truancy, fighting with parents or guardians and use of alcohol or drugs. However, being arrested by the police or detained by the juvenile justice system significantly increases the likelihood that a teen will engage in suicidal behavior. Suicide within juvenile detention and correctional facilities is more than four times greater than in the general population.

Exposure to suicide

Suicide risk is increased in young people who are exposed to another's suicide, especially when the person has celebrity status or there is a strong identification with the person because of similar age or circumstances.

This sometimes results in a "cluster" of suicide deaths occurring among teens in the same community over a relatively short period of time. In some cases, the teens may have been acquaintances, teammates or friends, but young people can be strongly affected just by hearing about another teen's suicide in the news, especially if the reporting of the incident is not handled appropriately.

In recent years, researchers and suicide prevention experts have become more aware of factors that can increase the likelihood of "suicide contagion." In particular, newspaper articles that show pictures of the deceased teen or the site of the suicide, or present the suicide in a romanticized or glamorized way contribute to the phenomenon. Memorial writings or speeches that idealize the deceased teen or attribute the suicide to a common stressful experience, such as the break-up of a relationship, are also problematic. Teachers and other school personnel should be mindful of the danger of contagion in their responses to suicides that occur in the community, and especially in the school. In addition, teens are increasingly exposed to reports of suicidal feelings and behaviors through social networking websites. Such exposure is particularly difficult to control and its effects on youth are only beginning to be documented.

Access to lethal means

Accessibility to lethal means for suicide — especially firearms and medications contributes to suicide among persons of all ages, and adolescents are no exception.

The presence of improperly secured guns in the home is a clear risk factor for suicide among adolescents, both boys and girls, and a particular risk in homes where someone is suffering from a mental health disorder. Among

Americans overall, about 85% of suicide attempts with a firearm are fatal. Safe storage and limited access to lethal means are important, especially in times of increased stress or the presence of a mental health condition.

SUICIDE WARNING SIGNS

The risk factors for teen suicide we have discussed so far in this section of the program generally endure over some period of time. While factors such as a mental disorder or a prior suicide attempt significantly increase an individual's longer-term risk of completing suicide, they may not alert an observer to the person's risk for suicide in the near-term (i.e., within minutes, hours or days). Thus, numerous efforts have been made to define "warning signs" that signal imminent suicide risk, analogous to the specific physical signs that warn of stroke or heart attack. This effort has been limited, however, by a paucity of research on behaviors that reliably predict imminent suicide risk. In addition, some of the factors that research has established to be associated with near-term suicide are internal emotional states that may not be directly observable by others (for example, feeling intensely angry, hopeless or trapped, or that life has no purpose). Most suicide prevention experts agree that the clearest warning signs for suicide are behaviors that indicate the person is thinking about or planning for suicide, or is preoccupied or obsessed with death.

These include:

- Talking about wanting to kill oneself/end one's life
- Looking for ways to kill oneself, such as searching the internet for suicide methods or seeking access to firearms, pills or other means of suicide
- Talking or writing about suicide
- Talking or writing about death or dying in a way that suggests preoccupation

The following changes are less precise as warning signs of suicide because they suggest the presence of a mental disorder that may or may not include suicidal thoughts or plans:

- Deterioration in academic, work or social functioning
- Talking about unbearable pain, hopelessness or feeling like a burden to others
- Increased alcohol or drug abuse
- Withdrawal from family or friends
- Depressed or irritable mood, or a recent humiliation
- Changes in personality, mood or behavior, including eating or sleeping patterns

Sadly, far too few adolescents who suffer from a mental health condition get the help they need. In the case of those with depression, for example, it is estimated that only one out of three receives any kind of treatment for the disorder. In many cases, this is because neither the teens themselves nor the adults who are close to them recognize the symptoms as a treatable illness. Other youth may know something is wrong but resist treatment because they are afraid of what it involves. Additional barriers to treatment among adolescents with a mental disorder include:

- Belief that nothing can help
- Perception that seeking help is a sign of weakness or failure
- Feeling too embarrassed to seek help
- Belief that parents and other adults aren't receptive to hearing about teens' mental health problems

These barriers are particularly regrettable because effective treatments for adolescents with mental health disorders do exist. The most common disorder, depression, is one of the most treatable of all. Studies show that over 80% of people with depression can be successfully treated, although in some cases, several different treatments need to be tried before an effective one is found.

Effective treatments for depression include psychotherapy (talk therapy), medication, or a combination of the two. Some adolescents with depression show considerable improvement with supportive psychotherapy alone, in particular a structured, time-limited form of psychotherapy known as cognitive-behavioral therapy (CBT). A majority of adolescents whose depression does not improve within the first 4–6 weeks of treatment with psychotherapy alone will respond well to treatment with antidepressant medication. In most cases, such medication results in significant alleviation of depressive symptoms within two months, although some people will need to try different medications to find one that effectively reduces symptoms and is well-tolerated. In addition to psychotherapy and in recent years, there has been some controversy about prescribing antidepressant medication to children and adolescents.

Since depression is caused by a change in brain chemistry, the purpose of antidepressant medication is to restore the brain chemistry back to the way it's supposed to be. Most people who take antidepressants experience positive changes, including sleeping better, feeling more energetic, thinking more clearly, and being more sociable and more interested in what's going on around them. However, for reasons that are not yet completely understood, antidepressants may trigger agitation and abnormal behavior in certain individuals, and in a small percentage of cases, this may include an increase in suicidal thinking and behavior. In clinical trials in which antidepressant medications were prescribed to adolescents, 4% reported these symptoms, compared to 2% of those given a placebo or "dummy" pill.

As a result, in 2004 the Food and Drug Administration (FDA) began requiring that antidepressants be labeled with a "black-box" warning that they may increase suicidal thinking and behavior in children and adolescents with depression and other mental health disorders. The FDA warning also underscored

the importance of closely monitoring children and adolescents taking these medications for any worsening in depression, emergence of suicidal thinking or behavior, or unusual changes in behavior, such as sleeplessness, agitation, or withdrawal from normal social situations. Although no completed suicides were reported by any of the studies reviewed by the FDA, the recommended precautionary measures are currently the standard of practice among physicians and mental health professionals.

Medication is usually essential in treating the most serious mental health disorders, such as a severe depression or eating disorder, bipolar disorder or schizophrenia. For people suffering from a severe mental disorder, the scientific advancements that have led to the development of modern psychiatric medications can be truly life-saving. Supportive psychotherapy is also commonly used as a supplement to medication in treating serious mental illness.

There are also approaches to help teens and their families to manage suicidal ideation and behavior that may emerge. Safety planning, Dialectical Behavior Therapy (DBT) and Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) as well as Attachment Based Family Therapy (ABFT) have been found to be helpful. Exercise, yoga, breathing techniques and changes in diet may also be added to help improve mood, relieve anxiety and reduce the stress that contributes to depression.

Studies have found that as many as 60% of adolescents with major depression experience suicidal thinking during the three months prior to starting treatment, and 30% have made a pre- treatment suicide attempt. Thus, the risks of antidepressant medication must be weighed against the risks of not prescribing medication. There is strong research evidence that early treatment with psychotherapy and medication can stop the symptoms of depression from becoming more severe and long-lasting, lessen the possibility of recurrence, and reduce the risk of suicide as an outcome. In any individual case, however, decisions about a specific course of treatment should be made by an experienced physician or mental health professional in consultation with the adolescent's parents or guardians.

It should be emphasized that mental health conditions may recur, even if treated effectively at one point in time. Part of successful long-term treatment involves helping the teen and the adults who are close to them become aware of signs that the problem may be recurring. Generally, regular, on-going monitoring by a physician or a mental health professional will be advised to ensure that symptoms are kept under control.

The essential point to remember is that effective treatments are available for adolescent mental health conditions. Once in treatment, most teens with one of the disorders we have described will show not only improved mental health, but also marked improvements in their attitudes and behaviors in relation to school, social interactions and use of alcohol or illicit drugs.

How Can Teachers Identify At-Risk Students?

The school environment provides valuable opportunities for teachers and other personnel to observe students' behavior and notice changes that may signal a problem requiring treatment by a trained mental health professional. As noted in earlier sections of this program, signs of serious mental health conditions in teens are often misinterpreted as normal adolescent mood swings or attributed to characteristics such as laziness, poor attitude or immaturity. To maximize recognition and referral of students with mental health disorders, all school personnel who interact regularly with students should become familiar with the ways in which depression and other mental health disorders can be expressed in adolescents.

The American Foundation for Suicide Prevention (AFSP) has developed a film for adolescents called *More Than Sad: Teen Depression* to help them recognize depression in themselves or their friends and encourage them to seek help. The film's realistic portrayal of four depressed teens also helps adults who live or work with adolescents understand what depression can look like in teens and recognize the warning signs that a teen may need help.

The messages conveyed by the film are as important for school personnel as they are for students and parents. These include the following:

- Depression is a common problem that can interfere with teens' ability to function well in school, enjoy previous hobbies or activities or interact effectively with friends or family members.
- Depression is an illness. It is not a character weakness or something that people bring on themselves or can change at will.
- Depression may develop after a particularly upsetting event or situation, but also develops in young people who don't seem to have any reason to be depressed.
- Depression usually doesn't go away on its own. If left untreated, it may lead to serious consequences, including suicide.
- Treatments for depression are available, and treatment works. If you are depressed, ask for help. If someone you know is depressed, encourage them to get help. Seek out the assistance of a trusted and knowledgeable person as this may save a life.

In the next section of this program, you will view *More Than Sad: Teen Depression*. While watching the film, try to look for behaviors you have seen in your students, and think about how you may have interpreted or reacted to these behaviors. After viewing the film, we will consider steps that teachers and other school personnel can take to respond effectively to the kinds of problems these four students experienced.

VIEWING *MORE THAN SAD: TEEN DEPRESSION*

The running time for this DVD is 26 minutes. We suggest that you have paper and a pen handy to write down points that you want to remember, or any questions that come to mind.

AFTER THE VIEWING: QUESTIONS TO CONSIDER

If you are taking this educational program on your own, we suggest that you take a few minutes to think about the following questions, which help to highlight the key messages of *More Than Sad: Teen Depression*. You may find it helpful to jot down your response to each question, and refer to them as you read the material that follows the questions.

If you are participating in a group training or in-service program, you are encouraged to share your answers to the questions with others in your group.

- Which of the four students in the film would you have been most likely to recognize as being depressed? Why? Were there any you would not think of as being depressed?
- What differences did you notice about the ways that depression was expressed in the four students shown in the film?
- What does the film say about the causes of depression in teens?
- In the film, the four students — Jake, Lana, Ray and Delia — got help because either the student himself or a caring adult suspected something was wrong and took appropriate action. From your perspective within the school, what behaviors might you have noticed in each of these students? Would you have associated these behaviors with a possible mental health problem?
- If you notice behaviors in a student that you think might be signs of a mental health condition, what are the best steps to take?
- Are you familiar with your school's policy regarding mental health referrals?
- Did the film change any of the ideas you might have had about depression or other mental health disorders in adolescents, or how they are best treated?

SUMMARY POINTS

1. Most people think someone who is depressed will be sad, teary and withdrawn, like Lana is portrayed in the film. But depressed teens can also be anxious, oppositional, angry, lethargic or seem constantly bored. They may express their pain through complaints of physical symptoms such as stomach problems or headaches.

2. Although they can exist as separate disorders, depression, anxiety and drug or alcohol abuse are often interrelated in teens. Remember, when depression is accompanied by severe anxiety and/or substance abuse, the risk of suicide increases significantly.

3. Most students with major depression will exhibit behaviors that can be observed in the school environment, although some may try to put up a "front" around teachers and school officials. Lana's shift from a responsible, high-achieving student to one who came to class unprepared (if at all); Ray's excessive worrying despite his high

scholastic and athletic functioning; Jake's irritability, out-of-control drinking and blaming others for his problems and Delia's withdrawal and refusal to attend school after being humiliated by her peers, were — in each case — observable signs of a serious disorder that required professional mental health treatment.

4. As shown in the film, one person's willingness to act led each of these students to get the help that he or she needed. School personnel are in a unique position to notice and speak up about changes in student behaviors that may point to a serious mental health concern. Remember, one person's actions can save a life.

5. All school personnel should become familiar with their school's policies and procedures for referring students for mental health evaluation or treatment. Generally, a teacher who is concerned about an individual student is best advised to discuss these concerns with the appropriate school administrator and a school counselor, if one is available. In most cases, a trained mental health professional will be in the best position to take the next steps, which may include talking to the student or to the student's parents or guardian. If the teacher has a close connection to the student or the family, he or she may be asked to attend the parent meeting. It can be helpful for parents to hear the information from someone they know and trust, and make it less likely that they will become defensive. In talking to families, teachers and other school personnel who are not trained mental health professionals should be careful to avoid speculating about the presence of a particular mental health disorder or diagnosis. Rather, try to describe the behaviors or changes you have observed in the student as clearly and objectively as possible, without evaluation or judgment.

6. Remember, if you are concerned about a student's well-being, tell someone who is in a position to help. Getting help for a problem at an early stage can prevent it from developing into a more serious disorder that can put the student's life at risk.

7. If a teacher or another adult in the school environment learns from a student that he or she is thinking about suicide, planning for suicide or engaging in suicidal behavior — or if a student reports such thoughts or behavior in a friend — it is essential that this information be communicated to an administrator and a school counselor or mental health professional, if one is available. School personnel should never promise a student to treat such information as confidential in return for the student's promise not to hurt or kill himself or herself.

8. All school personnel should be familiar with the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), a free, 24-hour hotline available to anyone in suicidal crisis or emotional distress. This confidential service routes calls from persons in distress, or someone who cares about them, to the nearest crisis center within a network of more than 140 centers nationwide.

How Else Can Schools Decrease Risk?

Because mental health disorders play such a central role in teen suicide, we have devoted most of our attention in this program to helping teachers and other school personnel recognize the signs and symptoms of the most common disorders in adolescents and understand how they are most effectively treated. The most important contributions to preventing teen suicide that a teacher or other adult in the school environment can make are:

1. Identifying students whose behavior suggests the presence of a mental health concern, and
2. Taking the necessary steps to insure that such students are referred to a mental health professional for evaluation and treatment, as needed.

In this section, we briefly describe other strategies that teachers and other school personnel may use to support good mental health among students and reduce the risk of losing lives to suicide.

EDUCATE STUDENTS ABOUT MENTAL HEALTH CONDITIONS

Researchers who have studied why so few teens seek help for depression and other mental health conditions have found that among the reasons most commonly cited are two that have particular relevance for school personnel: "I wouldn't know what to say to school counselors or teachers about my problems," and "I don't feel close to any adult at school." These concerns suggest the need for school personnel to educate students about mental health conditions, and talk with them directly when their behaviors suggest that they may be having a problem.

Showing the film *More Than Sad: Teen Depression* in a classroom or other relatively small group setting is an excellent way to help students understand and put words around what they may be feeling, or observing in a friend. The Facilitator's Guide (included in the DVD package), provides a sample lesson plan for showing the film that includes topics for discussion and a pre-post quiz to help students measure what they have learned.

We encourage classroom teachers to invite a school nurse or a school psychologist, social worker or other counselor to attend the class in which the film is shown. This provides an opportunity for students to be introduced to someone within the school environment who is available to talk with them about individual problems and make appropriate referrals as needed. Preparing for and showing the film also helps teachers feel more comfortable with the subject of teen depression and with identifying and referring students who are showing signs of depression or another mental health disorder.

EDUCATE PARENTS ABOUT MENTAL HEALTH CONDITIONS AND SUICIDE RISK

Schools are also in a position to help parents enhance their knowledge about mental health conditions and other factors that put youth at risk for suicide, available treatments and suicide prevention strategies and resources. Schools may wish to present the More than Sad: Parent Education program to educate parents about suicide risk. Additional resources that can be recommended to parents are listed at the end of this manual.

SUPPORT SCHOOL SAFETY AND REDUCE BULLYING

In many communities, teachers and school administrators —sometimes in collaboration with parents and concerned community members — are making efforts to reduce bullying, harassment and victimization among students that contribute to mental health conditions and increase suicide risk among both victims and perpetrators. Many schools have included a clear statement about sanctions for bullying and related behaviors in their disciplinary policies, and are initiating programs that seek to change the school culture to be more inclusive and supportive of differences among students.

Schools may wish to consider adopting one of a number of programs intended to reduce school-based bullying. Several of these are specifically designed to reduce bullying of gay, lesbian, bisexual or transgender (LGBT) students, but can be adapted to include all students who are affected by bullying, regardless of the reason. Information about anti-bullying programs can be obtained from the websites of the following organizations:

- The Safe Zone Program: www.safezonefoundation.tripod.com
- Gay-Straight Alliance Network: www.gsanetwork.org
- Gay, Lesbian and Straight Education Network: www.glsen.org

SUPPORT GUN SAFETY PROGRAMS

Many schools, especially in states and communities where gun ownership is high, are partnering with law enforcement, public health agencies and parent groups to prevent suicide and homicide deaths among children and adolescents by promoting proper gun storage and reducing opportunities for unsupervised access to firearms by youth.

Additional Resources

WEBSITES WITH INFORMATION ABOUT SUICIDE PREVENTION

American Foundation for Suicide Prevention (AFSP): www.afsp.org

American Association of Suicidology (AAS): www.suicidology.org

Suicide Prevention Resource Center (SPRC): www.sprc.org

Substance Abuse and Mental Health Services Administration (SAMHSA): www.mentalhealth.samhsa.gov/suicideprevention/

National Suicide Prevention Lifeline: www.suicidepreventionlifeline.org

Suicide Awareness Voices of Education (SAVE): www.save.org

National Association of School Psychologists (NASP): www.nasponline. org/resources/crisis_safety/suicideresources.aspx

SAMPLES OF PROTOCOLS AND GUIDELINES FOR SCHOOLS

Maine Youth Suicide Prevention Guidelines: www.maine.gov/suicide/

Florida Youth Suicide Prevention Guide: http://theguide.fmhi.usf.edu/

Los Angeles Unified School District's Resource Page: http://notebook. lausd.net/portal/page?_pageid=33,1049567&_dad=ptl&_ schema=PTL_EP

Model School Policy: http://www.afsp.org/preventing-suicide/our-education-and-prevention-programs/programs-for-teens-and-young-adults/a-model-school-policy-on-suicide-prevention

VIDEOS

Two segments of the *Healthy Minds* series, produced for public television (WNET.org) by WLIW21, New York, NY, cover issues related to teen mental illness:

Teens: Typical or Troubled

Part I: What You Need to Know Part II: Suicide Prevention

Videos are available online at: www.wliw.org/healthyminds

PUBLICATIONS

Books for professionals who work with teens

Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention (School-Based Practice in Action). Terri A. Erbacher, Jonathan B. Singer, Scott Poland.

By Their Own Young Hand: Deliberate Self-Harm and Suicidal Ideas in Adolescents. Keith Hawton & Karen Rodham, with Emma Evans. Jessica Kingsley Publishers, Philadelphia, 2006

Adolescent Suicide: Assessment and Intervention, 2nd Ed. Ronald W. Maris, Alan L. Berman, & Morton M. Silverman. American Psychological Association, Washington, D.C., 2005

Treating and Preventing Adolescent Mental Health Disorders: What We Know and What We Don't Know. Editors: Dwight L. Evans, Edna B. Foa,Raquel E. Gur, Herbert Hendin, Charles P. O'Brien, Martin E.P. Seligman & B. Timothy Walsh. Oxford University Press, New York, 2005

Night Falls Fast: Understanding Suicide. Kay Redfield Jamison. Alfred A. Knopf, New York, 1999

No One Saw My Pain: Why Teens Kill Themselves. Andrew Slaby & Lili Frank Garfinkel. W. W. Norton & Company, New York, 1996

Personal stories of mental disorders and suicide

Remembering Garrett: One Family's Battle with a Child's Depression.
Gordon H. Smith (Former U.S. Senator). Carroll & Graf, New York, 2006

Will's Choice: A Suicidal Teen, a Desperate Mother and a Chronicle of Recovery.
Gail Griffith. HarperCollins, New York, 2005

An Unquiet Mind: A Memoir of Moods and Madness. Kay Redfield Jamison. Alfred A. Knopf, New York, 1995

Books for teens and young adults

Eight Stories Up: An Adolescent Chooses Hope over Suicide. DeQuincy A. Lezine and David Brent. Oxford University Press, New York, 2008

The Thought That Counts: A Firsthand Account of One Teenager's Experience with Obsessive-Compulsive Disorder.
Jared Kant, Martin Franklin & Linda Wasmer Andrews. Oxford University Press, New York, 2008

Chasing the High: A Firsthand Account of One Young Person's Experience with Substance Abuse. Kyle Keegan & Howard Moss. Oxford University Press, New York, 2008

Monochrome Days: A Firsthand Account of One Teenager's Experience with Depression. Cait Irwin, Dwight L. Evans & Linda Wasmer Andrews. Oxford University Press, New York, 2007

What You Must Think of Me: A Firsthand Account of One Teenager's Experience with Social Anxiety Disorder.
Emily Ford, Michael Liebowitz & Linda Wasmer Andrews. Oxford University Press, New York, 2007

Me, Myself and Them: A Firsthand Account of One Young Person's Experience with Schizophrenia. Raquel E. Gur, Linda Wasmer Andrews & Kurt Snyder. Oxford University Press, New York, 2007

Next to Nothing: A Firsthand Account of One Teenager's Experience with an Eating Disorder. Carrie Arnold & B. Timothy Walsh. Oxford University Press, New York, 2007

Mind Race: A Firsthand Account of One Teenager's Experience with Bipolar Disorder. Patrick E. Jamieson with Moira A. Rynn. Oxford University Press, New York, 2006

Books for parents

If Your Adolescent Has an Anxiety Disorder: An Essential Resource for Parents. Edna B. Foa & Linda Wasmer Andrews. Oxford University Press, New York, 2006

If Your Adolescent Has Schizophrenia: An Essential Resource for Parents. Raquel E. Gur & Ann Braden Johnson. Oxford University Press, New York, 2006

If Your Adolescent Has Depression or Bipolar Disorder: An Essential Resource for Parents. Dwight L. Evans & Linda Wasmer Andrews. Oxford University Press, New York, 2005

If Your Adolescent Has an Eating Disorder: An Essential Resource for Parents. B. Timothy Walsh & V. L. Cameron. Oxford University Press, New York, 2005

Test Your Knowledge

1. **Which of the following best describes gender differences in youth suicidal behavior?**
   a. Boys make more suicide attempts but girls are more likely to die by suicide.
   b. Girls make more suicide attempts but boys are more likely to die by suicide.
   c. Boys and girls are equally likely to attempt suicide but boys are more likely to die by suicide.
   d. Boys and girls are equally likely to attempt suicide but girls are more likely to die by suicide.

2. **Since the mid-1990s, suicide rates have:**
   a. Generally decreased
   b. Generally increased
   c. Increased and then leveled off
   d. Stayed about the same

3. **The racial/ethnic groups having the highest rates of youth suicide are:**
   a. Black and Hispanic
   b. White and Asian
   c. American Indian and Alaskan Native
   d. White and Hispanic

4. **Most suicides are the fatal outcome of:**
   a. Negative life events
   b. Inherited characteristics
   c. Vulnerability to stress
   d. Mental health disorders

5. **Which of the following is not usually a symptom of major depression?**
   a. Delusions
   b. Fatigue or loss of energy
   c. Sleep disturbances
   d. Diminished ability to concentrate

6. **In order to be diagnosed with major depression, symptoms need to last a minimum of:**
   a. 1 week
   b. 2 weeks
   c. 2 months
   d. 6 months

7. **Inflated self-esteem or grandiosity is most commonly associated with:**
   a. Conduct disorder
   b. Mania
   c. Eating disorders
   d. Depression

8. **Delusions and hallucinations are most commonly associated with:**
   a. Schizophrenia
   b. Conduct disorder
   c. Generalized anxiety disorder
   d. Substance use disorders

9. **Which mental health disorder is more common in girls than in boys?**
   a. Depression
   b. Generalized anxiety disorder
   c. Eating disorder
   d. All of the above

10. **Physical cruelty, lying and stealing are most commonly associated with:**
   a. Substance use disorders
   b. Conduct disorder
   c. Generalized anxiety disorder
   d. Bipolar disorder

11. **Which of the following statements is not true?**
   a. A teen whose parent has depression is more likely to develop depression.
   b. A teen whose parent attempted suicide is more likely to attempt suicide.
   c. Many mental health disorders have a genetic component.
   d. Conduct disorder rarely has a genetic component.

12. **Which of the following statements is true?**
   a. Most mental health disorders cause emotional but not behavioral changes.
   b. Most teens with mental health disorders show observable changes in behavior.
   c. Only a trained mental health professional can recognize signs of a mental disorder in teens.
   d. Parents are usually in a better position than teachers to notice signs of a mental health disorder in a teen.

13. **Which of the following is associated with high rates of depression in gay, lesbian, bisexual and transgender youth?**
    a. Rejection by parents
    b. Ostracism and bullying by peers
    c. Alcohol and drug use
    d. All of the above

14. **A "cluster" of teen suicides in a particular community or area is most likely to be a result of:**
    a. High unemployment
    b. Lack of parental supervision
    c. Exposure to suicide or contagion
    d. All of the above

15. **Approximately what percent of depressed teens receive some form of treatment?**
    a. 10%
    b. 30%
    c. 50%
    d. 80%

16. **A teacher's responsibility toward a student who shows signs of a possible mental disorder is best described as:**
    a. Listening and counseling
    b. Questioning and advising
    c. Identifying and referring
    d. None of the above

17. **Which of the following statements about treatment for depression is not true?**
    a. 80% of people with depression can be successfully treated.
    b. Psychotherapy can be an effective treatment for depression in teens.
    c. If psychotherapy is ineffective in relieving depression symptoms, antidepressant medication is also likely to be ineffective.
    d. About two-thirds of teens with depression do not receive treatment for the disorder.

18. **A 10th grade English teacher observes that lately, a student's essays have frequently had themes of violent death. After discussing this with the principal and a school counselor, the teacher is invited to sit in on a meeting with the student's parents. Which of the following would be the best way for the teacher to present what she has observed?**

    a. "Your son's writing shows signs that he may be suicidal. I believe he needs to see a doctor."

    b. "I've noticed lately that your son has been writing a lot about violent death, which seems quite different from his essays earlier in the year. I'm wondering whether he would benefit from talking to someone about this."

    c. "Your son's essays have been very bizarre lately. I'm concerned that he might be developing a mental health disorder."

    d. "Your son is writing a lot about death, which is often a sign of serious depression. I think he needs to talk to a therapist."

19. **teachers can play a role in preventing suicide by:**

    a. Referring at-risk students to the appropriate helping resource

    b. Helping students learn about mental health disorders

    c. Supporting programs in the school and community that reduce suicide risk

    d. All of the above

correct answers:
1 = b; 2 = a; 3 = c; 4 = d; 5 = a; 6 = b; 7 = b; 8 = a; 9 = d; 10 = b; 1 1 = d; 1 2 = b; 1 3 = d; 1 4 = c; 15 = b; 16 = c; 17 = c; 18 = b; 19 = d

PARTICIPANT FEEDBACK

After completing this educational program, we urge participants to complete and submit a Participant Feedback Form, which can be downloaded from the website MoreThanSad.org. Your comments and suggestions will help us in our continuing efforts to provide teachers and other school personnel with relevant, useful and timely information about their important roles in suicide prevention.

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