AMERICAN ACADEMY OF PEDIATRICS

Committee on School Health

The Potentially Suicidal Student in the School Setting

The increasing suicide rate in adolescents and young adults is of concern to both pediatricians and educators.[1] The 1988 statement of the Committee on Adolescence addressed the issue from the pediatrician's perspective.[2] There is, however, a need for pediatricians and educators to collaborate in identifying and helping youngsters at risk for suicide whose symptoms of distress may become manifest in the school setting.

STUDENTS AT RISK

Among those at increased risk for a suicide attempt are students who have made a previous attempt or who have a family history of suicide, who may be suffering from a genetically determined depression (either endogenous or associated with a bipolar disorder or schizophrenia), who have been physically or sexually abused, who are confused about their sexual identity or who are homosexual and having difficulty finding acceptance, who are abusing alcohol or other drugs, and who may have problems with self-esteem due to chronic illness or learning disabilities.[2-8] Perfectionistic individuals, who appear to be well-adjusted superachievers, may become overwhelmed by situations they cannot control.[4] In some instances, suicide appears to have been impulsive, and students at risk are not always identified easily.

Events which may precipitate a suicide attempt in a vulnerable student include recent death of a family member or pet, loss of a job, examination failure, rejection by a friend, a broken romance, an arrest, or other humiliation.[4] A feeling of hopelessness with no belief in any alternative is often a final common denominator.[5]

BEHAVIORAL MANIFESTATIONS OF DEPRESSION

The potentially suicidal adolescent may display either the classic symptoms of depression, such as eating and sleeping disturbances, physical complaints, sad appearance, and lack of interest in friends and usually pleasurable activities; or he/she may display acting our behaviors, such as irritability, aggressiveness, destructiveness, and unpredictability; or he/she may abuse drugs or alcohol in an attempt to self-medicate underlying feelings of emptiness, worthlessness, and recurrent thoughts of suicide.

DETECTION OF THE POTENTIALLY SUICIDAL STUDENT

Because of the varied expression of depression in adolescents, students needing help may appear in different ways within the school community.

School Clinic or Nurse's Office

Recurrent headaches, abdominal pain, and other physical complaints associated with chronic depression may result in frequent appearances by the student in the school clinic. Planned periodic record review may allow school health personnel to recognize this occurrence of depressive symptoms. Sympathetic questioning may uncover suicidal ideation and necessitate immediate referral for evaluation and therapy.

The Classroom

Disruptive classroom behavior, apparent boredom, tardiness or truancy, and, in particular, falling grades may indicate the onset of a depression and

This statement has been approved by the Council on Child and Adolescent Health.

The recommendations in this statement do not indicate an exclusive course of treatment to be followed. Variations, taking into account individual circumstances, may be appropriate.

should indicate the need for sympathetic questioning rather than punitive measures by classroom teachers and parents. Planned periodic review of students experiencing difficulty, by a team of teachers, the guidance counselor, and school psychologist, might serve to identify the student at particular risk.

The Administrative Office

Students at risk for suicide who come to the central office are likely to abuse drugs or alcohol, display aggressive or destructive behavior, or be habitually truant. Some may have arrest records. Referral of these students to a mental health center or drug treatment program is of critical importance. Simply expelling the student from school is not adequate management of the problem and may increase the risk of suicide.[4]

PREVENTION OF SUICIDE

Referral of Students

Each school system should have a predetermined mechanism for referral of a student felt to be at risk for suicide. Parents should be consulted on an urgent basis and a determination made as to whether the student has a physician who can be consulted. If the student does not have a physician, school personnel should consult with the school medical advisor and suggest competent referral resources within the community that can respond to the crisis.

If a student attempts suicide on school property, school personnel should make sure that the student receives an emergency psychiatric consultation within a hospital setting. The school medical advisor, after consultation with the student's physician, can help to facilitate the student's return to school.

Education

Each school system should have an *ongoing* program that educates faculty and administrators concerning the behavioral manifestations of depression in adolescents. Procedures for referral should be outlined clearly.

As part of a comprehensive health education curriculum, students should be made aware of the symptoms of depression and the available sources of help. The necessity of taking seriously and reporting immediately suicide ideation in themselves or their friends to the school nurse or a sympathetic teacher should be stressed. The majority of students who commit suicide have communicated their wish to die to siblings or friends shortly before death.[6] Ominous signs include giving away treasured possessions and having a well-thought-out plan for suicide.

Education of parents through newsletters and parent-teacher seminars as to symptoms of depression and the necessity of seeking immediate treatment is important. The availability of firearms is a significant risk factor for successful suicide attempts.[6,7] Parents should be advised that guns should not be accessible.[6]

MANAGING THE AFTERMATH OF A COMPLETED SUICIDE

In spite of suicide prevention programs, suicide sometimes occurs. The announcement of the death is probably best made in individual classrooms by teachers or guidance counselors who knew the student, rather than in a special assembly or over the public address system. Care should be taken to downplay the drama of the event. Administrators may bring in a crisis intervention team to assist local school personnel and to handle information-sharing with parents and the media. Parents of other students should be encouraged to discuss the death with their own children so that they can understand how deeply their children are affected.

Students who are contemplating a similar suicide may display unusual interest in the details of the death, make more than one visit to the funeral home or gravesite, or seem obsessed with the event even though the student may not have been a close friend. Parents or teachers observing such behavior should seek immediate professional help for the student.

SUMMARY

Education about depression and identification and referral for treatment of the depressed or drug-abusing student are important strategies in reducing the tragedy of suicide among adolescents. Pediatricians should work with local school personnel toward the implementation of the suicide-reduction strategies identified in this statement. The American Academy of Pediatrics strongly recommends that prevention programs be built into the education system. To be successful, such programs must involve school personnel, community medical professionals, child psychiatrists, students, and parents.

COMMITTEE ON SCHOOL HEALTH, 1989–1990
Martin C. Ushkow, MD, Chairman
John R. Asbury, MD
Bradley John Bradford, MD
Philip R. Nader, MD
Steven R. Poole, MD
Daniel Charles Worthington, MD

Liaison Representatives

Arthur B. Elster, MD, American Medical Association

Vivian Haines, RN, MA, SNP, National Association of School Nurses, Inc.

Paul W. Jung, EdD, American Association of School Administrators

Patricia Lachelt, RN, CPNP, National Association of Pediatric Nurse Associates and Practitioners

R. Dee Legako, MD, American Academy of Family Physicians

John Santelli, MD, American School Health Association

James H. Williams, MEd, National Education Association

Consultant

Beverley J. Bayes, MD

REFERENCES

1. *Mental Health, United States.* Rockville, MD: National Institute of Mental Health, Division Biometry and Epidemiology; 1983. US Dept of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration publication GD HE-20-8137
2. American Academy of Pediatrics, Committee on Adolescence. Suicide and suicide attempts in adolescents and young adults. *Pediatrics.* 1988;81:322–324
3. Hodgman C H. Recent findings in adolescent depression and suicide. *J Dev Behav Pediatr.* 1985;6:162–170
4. Shaffer D, Garland A, Gould M, Fisher P, Trautman P. Preventing teenage suicide: A critical review. *J Am Acad Child Adolesc Psychiatry.* 1988;27:675–687
5. Beck AT, Steer RA, Kovacs M, Garrison B. Hopelessness and eventual suicide: A 10-year prospective study of patients hospitalized with suicidal ideation. *Am J Psychiatry.* 1985;142:559–563
6. Brent DA, Perper JA, Goldstein CE, et al. Risk factors for adolescent suicide. A comparison of adolescent suicide victims with suicidal inpatients. *Arch Gen Psychiatry.* 1988;45:581–588
7. Boyd JH, Moscicki EK. Firearms and youth suicide. *Am J Public Health.* 1986;76:1240–1242
8. Remafedi G. Adolescent homosexuality: Psychosocial and medical implications. *Pediatrics.* 1987;79:331–337

The Potentially Suicidal Student in the School Setting

Committee on School Health

Pediatrics 1990;86;481

The Potentially Suicidal Student in the School Setting

Committee on School Health

Pediatrics 1990;86;481