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Teen Suicide & Suicide Clusters: A Community Health Problem

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Suicide is the 3rd leading cause of death for teens with approximately 10 teens taking their lives daily in the United States. This does not account for all those who have attempted to take their lives as there is no effective way of collecting this data. Delaware County is no different. We currently have a community health crisis as we have lost 4 teens from the same school district to suicide in the past month. We need to work together to prevent more loss…and need to act now!

The following is extracted from a story published on NPR – see entire story here:
http://www.npr.org/templates/story/story.php?storyId=120755264

What does the research say?
Scientists define a suicide cluster as three or more suicides in a specific location that occur over a short period of time. On average, there are five suicide clusters each year in the United States, according to psychiatric epidemiologist Madelyn Gould at Columbia University in New York.

Dr. Gould has found that suicide clusters are a relatively rare event, accounting for fewer than 5 percent of all suicides in teenagers and young adults. The most distinctive feature about suicide clusters is that they occur almost exclusively in teenagers, she says. "Suicides following the exposure to someone's death by suicide, was about two to four times higher among 15- to 19-year-olds than [in] other age groups," Gould says. So what is it about teenagers that make them particularly vulnerable? For one, Gould says, adolescents are intensely focused on other teenagers and on imitating the behaviors of other teens. It's a developmental phenomenon that scientists call "social modeling." And for adolescents, says Gould, "it's the peer group members who often serve as models. So during this age it's the peers that replace family members and other adults as the most influential group. And suicide is another behavior that can be modeled, unfortunately."

Another characteristic typical of teenagers that puts them at increased risk of suicide is their tendency to act impulsively. This behavioral inclination is a function of a still-maturing brain. Neuroscientists have found that complex cognitive functions — such as inhibiting impulsive behaviors, planning ahead, and problem solving — occur in the prefrontal cortex, a brain area that continues to develop throughout adolescence and into young adulthood. So until an adolescent's brain is more fully mature, he or she will tend to behave impulsively, neglect future consequences, and perhaps view suicide as an immediate solution to problems, especially if a friend or acquaintance has taken that route

What is the role of the media?
In preliminary findings, Gould reports that there is no one type of community that is more susceptible to suicide clusters than another. Gould has identified a crucial characteristic that seems to play a critical role in suicide clusters. If the first suicide gets media attention, then it's more apt to trigger other suicides. So, Gould cautions, the way the media cover a suicide can be critical. There are ways that the media can cover a suicide that can actually help mitigate the risk of additional suicides, says psychiatrist Paula Clayton, medical director of the American Foundation for Suicide Prevention. For example, they should report on the many complex factors that may have led up to the suicide and emphasize that 90 percent of people who kill themselves have mental health problems. Clayton cautions, though, that using details about a suicide can increase the risk of suicide clustering. "Don't talk about the method, or show the place where the suicide occurred. And don't glorify it," she says.

How can we prevent more deaths?
In terms of prevention, one of the most highly effective deterrents to suicide, says Clayton, are physical suicide barriers. Gould agrees barriers can prevent suicides, especially in impulsive teenagers. "If you can

make it that much harder, at least you're buying time. And we have found that to be effective because the motivation to [commit] suicide is not constant. It waxes and wanes. And so you might get them past that impulsive urge." Means restriction (limit access to firearms/analgesics) is an integral prevention strategy to get adolescents past this impulsive time.

In addition, suicide screening of all the teenagers in a community where a suicide has occurred is also effective in identifying kids with depression, anxiety or substance use. A new study by Gould, to be published in the December issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*, confirms the value of schoolwide suicide screening. Her study shows that identifying teens at risk for suicide and offering them help does result in the teenagers' getting treatment for their mental health problems.

Further, a review published in October's *Current Opinion in Pediatrics* (Horowitz, Ballard, Pao, 2009) finds that schools, primary care settings and emergency departments are key locations for early identification of youth mental illness and suicide prevention. Validated screening tools identify suicide risk in adolescents who may otherwise go unnoticed—The Columbia Suicide Screen, the Pediatric Symptom Checklist and the Guidelines for Adolescent Depression in Primary Care (GLAD-PC), as well as the Risk of Suicide Questionnaire in emergency departments, were found effective in assisting health professionals in finding at-risk patients. Primary care and emergency department settings were found to be particularly well-equipped to initiate further assessment for positive screens (www.teenscreen.org). Further, physicians have a unique relationship with their patients and families, and the primary care office is a setting where mental health issues may be more easily normalized by families if they are put into the context of a general screening (www.chw.org).

FREE Screening Materials for Physicians are available at:
http://www.teenscreen.org/teenscreen-primary-care

School Screenings: Further, as mentioned above, Dr. Gould makes a point that universal school screenings are integral to identifying and treating those at risk. The American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC) have begun doing research to create a Best Practices Registry of Evidenced Based Programs and Practices. Information on this can be found here: http://www.sprc.org/featured_resources/bpr/ebpp.asp

Specifically, a few options for School Screenings are provided below. Teen Screen and SOS have been found to be Promising by the Best Practices Registry. Jason Foundation is Free with local representatives in Pennsylvania. *Options are provided to meet the varying needs of schools.*

SOS Signs of Suicide – Ages 13-17
http://www.mentalhealthscreening.org/highschool

Teen Screen – Ages 11-18
www.teenscreen.org

Jason Foundation – Grades 7-12 – Also has a Parent Program and Staff Training – FREE!
www.jasonfoundation.com

Yellow Ribbon Program – Teens, Parents, Staff Development
www.yellowribbon.org

What are some other things we can do?

Emergency Room Means Restriction Education for Parents: The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Lethal means covered include firearms, medications, and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised. A follow-up telephone interview of parents indicated that exposure to the means restriction education program resulted in a statistically significant increase in the self-reported restriction of means in their homes.
http://www.sprc.org/featured_resources/bpr/ebpp_PDF/emer_dept.pdf

Limits on Analgesic Packaging: In response to an increasing number of self-poisonings with analgesics in the United Kingdom, Parliament passed legislation in 1998 limiting the pack sizes of these drugs. Pharmacies were limited to 32 tablets per sale and non-pharmacy outlets were limited to 16 tablets. In addition, specific printed warnings about the dangers of overdose with these analgesics were included with all sales. Analyses demonstrated statistically significant decreases in rates of acetaminophen and salicylate self-poisonings (22%), hospital admissions for acetaminophen poisoning, listings for liver transplants following acetaminophen poisoning (31%), and actual liver transplants following acetaminophen poisoning (36%).
http://www.sprc.org/featured_resources/bpr/ebpp_PDF/analgesic_limits.pdf

References

Gould, M.S. (2010) Suicide Contagion (Clusters). Found at:
http://suicideandmentalhealthassociationinternational.org/suiconclust.html

Horowitz, L.M., Ballard, E.D., Pao, M. (2009, Oct.). Current opinion: Suicide screening in schools, primary care and emergency departments. Pediatrics, Vol. 21 (5), pp 620-627.

Moisio, S. (2010). The primary care physician's role in suicide prevention. Found at: http://www.chw.org/display/PPF/DocID/42731/Nav/1/router.asp.

Suicide Prevention Resource Center (2010). SPRC/AFSP Evidence-Based Practices Project. Found at: http://www.sprc.org/featured_resources/bpr/ebpp.asp.

Teen Screen Primary Care (2010). Found at: http://www.teenscreen.org/teenscreen-primary-care.

Trudeau, M. (2009, Nov.). Media should tread carefully in covering suicide. Found at: http://www.npr.org/templates/story/story.php?storyId=120755264.

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