

Suicide Prevention in Schools: The Art, the Issues, and the Pitfalls

Antoon A Leenaars, Susanne Wenckstern

Suicide is a major mental health problem and public health problem worldwide. Schools and their communities must respond in a comprehensive fashion. Caplan's model of primary, secondary, and tertiary prevention—or prevention, intervention, and postvention—is proposed as a comprehensive response to suicide in youths. Current myths and facts about these fabrications are discussed for each mode of response. Research, clinical suggestions, and a call for further discussion are presented.

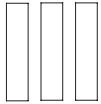
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Childhood and adolescent problems in adjustment have been an increasing concern in this century [Durlak, 1995; Glidewell & Swallow, 1969], beginning in 1910, when Sigmund Freud convened a special panel on the topic [Friedman 1910/1967]. Schools and communities are a natural environment to address these problems through prevention programs. Schools are institutions designed to aid in the child's development and to address his/her problems, through various programs, e. g., health programs, sex education, suicide prevention, drinking and driving programs. There are numerous reasons for these efforts in schools. The primary one is that health-care systems alone cannot meet all the needs of youths [Durlak, 1995]. Kazdin [1990] estimates that only 10 to 30% of youths currently receive needed mental health care, and that is in developed countries. It is likely that the lack in services will not disappear, calling on schools and their communities to increase response in the next millennium.

Suicide is a major mental health and public health

problem worldwide [Diekstra, 1996]. Adolescents, and even children, are committing suicide at alarming rates [Pfeffer, 1986]. An even greater number of youths attempt and/or seriously think about suicide as the solution to their life's difficulties [Berman & Jobes, 1991]. As was stated 90 years ago [Friedman, 1910/1967], schools/communities must respond. This paper provides an overview of the need to address suicide in our schools/communities and an outline for a comprehensive model to address the problem; it isolates some issues and pitfalls in what is being done today. Although many readers of *Crisis* may be familiar with the complexities of suicide prevention in schools, clearly delineating such efforts and their pitfalls for government bodies, educators, administrators, etc., is needed. Thus, this paper serves as a guide on suicide prevention in schools to government and local board entities responsible for reforming programs, administrators and planners concerned with prevention programs, administrators and educators working in schools,

mental health staff providing care in schools and health workers in the larger community who will be increasingly called upon to coordinate services with schools within a comprehensive community approach.



Suicide Prevention is an Art

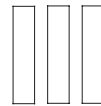
Suicide prevention is an art, not a technology. All too frequently, however, individuals respond to the suicidal crisis in our schools without an adequate understanding of this public health problem and without a prearranged comprehensive plan of action [Leenaars & Wenckstern, 1990a]. Sometimes individuals attempt to reinvent the wheel, making errors that are now well documented in the literature [Leenaars & Wenckstern, 1990a]. In such a case, it may well be better that nothing is done, that childhood and adolescent problems are left alone, and that schools do nothing. Schools, in such situations, may actually impede youths' development and even promote suicide [Centers for Disease Control, 1988]. However, if one accepts the complexity of suicide and adjustment in general in young people, only then, as was already documented 90 years ago [Friedman, 1910/1967], should schools actively play a role in prevention of suicide.

The rationale for beginning such a comprehensive suicide prevention program in schools includes the following:

1. The sheer numbers of suicides and suicidal behaviors in youths worldwide.
2. The large number of unhappy—many depressed—youths. As cited earlier, Kazdin [1990] reported that only 10 to 30% of youths needing clinical help actually receive that care. It can, thus, be asked: How many suicidal youths are also not identified as at risk?
3. There is a possible suggestibility or imitation factor and subsequent contagion. Reflecting on the first documented postvention in schools in the literature, Leenaars [1985] noted this fact, something subsequently supported by research [Martin, 1998].
4. Schools are asking for assistance. Thus, it would be wise that those most knowledgeable professionals (psychiatrists, psychologists, educators, etc.) assist.
5. The survivors of suicide are a striking reason. All too

many youths in our schools are traumatized by the suicide of their peers [Leenaars, 1985].

To conclude, there is a rationale for suicide prevention. The important question is not *that* we do it, but *how* we do it.



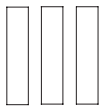
Prevention/Intervention/ Postvention

The classical approach to the prevention of mental health and public health problems is that of Caplan [1964], who differentiated between primary, secondary, and tertiary prevention. The more commonly used concepts for these three modes of prevention are prevention, intervention, and postvention, respectively. All three modes of response have a place in helping the suicidal youth in a reasonably prudent fashion. Briefly, these three modes of a comprehensive response refer to the following:

1. *Prevention* relates to the principle of good mental hygiene in general. It consists of strategies to ameliorate the conditions that lead to suicide: to do something before the event occurs. Preventing suicide is best accomplished through primary prevention. Prevention is education. Young people (and their gatekeepers) must be educated about suicide. Such education—given that suicide is a multidimensional malaise—is enormously complicated, almost tantamount to preventing human misery.
2. *Intervention* relates to the treatment and care of a suicidal crisis or suicidal problem. Secondary prevention is doing something during the event. Suicide is an event with biological (including biochemical), neuropsychological, sociocultural, interpersonal, psychological, and personal philosophical or existential aspects. Obviously, suicide is not solely a medical problem, and many people can serve as life-saving agents. Nonetheless, professionally trained people, psychologists, psychiatrists, social workers, psychiatric nurses, and so on, continue to play the primary roles in intervention. Although equally true for postvention, intervention in schools will call for the development of community linkages. Prevention in schools is prevention in the community.
3. *Postvention*, a term introduced by Shneidman [see

Shneidman, 1985], refers to those things done after the event has occurred. Postvention deals with the traumatic aftereffects in the survivors of a person who has committed suicide (or in those close to someone who has attempted suicide). It involves offering mental health and public health services to the bereaved survivors. It includes working with all survivors who are in need: children, parents, teachers, schoolmates, etc. School systems, as we stated initially, are an especially critical force in these endeavors.

Next, we will outline in some detail some myths, issues and pitfalls in each endeavor.



Prevention

Prevention relates to the principle of good mental hygiene in general. In schools, this means education. This is in keeping with the general aim of schools, namely to educate our youths.

A current popular formulation regarding suicide is that suicide is simply due to an external event or "stress"; for example, a rejection of a friend, the influence of a popular singer. Although there is often a situational factor in suicide, there is much more. To illustrate, we hereby provide a clinical example:

A 16-year-old was found dead in a car, having died of carbon-monoxide poisoning. People were perplexed, "Why did this young person, from an upper-middle-class family, kill himself?" The parents found out that his girlfriend had rejected him the day of his suicide. That was the reason: When a young person gets rejected and is so in love, he may kill himself. A few friends and his teachers knew that he had been having problems in school. So that was the reason. A few others knew that his father was an alcoholic and abusive. So that was the reason. His physician knew that he had been adopted and had been recently upset about that. So she knew the real reason. And others knew . . .

The youth himself or herself is equally often blinded by a single event. Here we are speaking about lethal suicidal people. The teenager who is about to put a bullet through his head with his father's gun, or the teenager who is about to take her mother's prescription pills, at the moment of decision, may be the least aware

of the essence of the reasons for doing so. The adolescent's conscious perception is a critical aspect. Yet, to simply accept that perspective is not only simplistic, but may well be suicidogenic (i. e., destructive, iatrogenic). The pain simply makes it impossible for the young person to give a complete and accurate recitation of the event. Suicide is complex, more complicated than the child's or adolescent's conscious mind is aware.

Regrettably, all too often, adults—including parents, teachers, medical doctors, psychologists—are willing to share in the misconception. Myths are, in fact, widespread. This has gone as far as some stating the following: "Suicide is normal." Suicide is not normal. It is an indication of major pathology [King, 1997]. To have stated otherwise—as occurred in the late 1970's and 1980's—was not only a pitfall but a disservice to prevention efforts.

Here are a few more misconceptions and our response to each of them.

1. *Suicide prevention has no place in schools.* Response: This is a system entry issue; this is a common concern, highlighting the need to begin the entry and development of such programs with administration, followed by school staff and other individuals involved. Dyck [1990] has noted the following: "Some Departments of Education, school boards, and even individual school administration have resisted the introduction of these programs in schools for a variety of reasons, some based more on myth than fact, and others that are legitimate and should be given serious and careful consideration" [p. 48]. Strategies for school entry include mandatory prevention programs through government, introduction through particular school boards, and, although the least effective, entry through a local school. It is, however, those clinicians/professionals who wish to gain entry, who must develop their skill before gaining access. Such skills include credibility, suicide prevention training, participation in education, conferences, research, etc. All too frequently, there are individuals with limited training and skills who are attempting to gain entry into schools, some of whom have been suicidogenic themselves.
2. *Talking about suicide will cause suicide.* Response: This is a myth. Of course, sensationalism will cause sensationalism. The issue is not that we talk about suicide but how we talk about suicide. Sound

discussion facilitates the openness of a suicidal person, leading to intervention. Talking about suicide and all mental health problems can lead to improving mental health and community skills, raise self-esteem, reduce school failure, increase self-control, reduce depression, etc., for all youths.

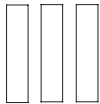
3. *Programs are not cost-effective.* Response: We believe that programs can be cost-effective, provided one has a clear understanding of the purpose. Prevention is intended to educate; e. g., to know about clues, resources, etc. They are not intended to be intervention. Thus, the issue of cost effectiveness, if one wants to use such terms, in education is one consistent with all schooling: Have the children/teens learned? We believe that they do [see Eggert, Thompson, Herting & Nicholas, 1995; Kalafat & Elias, 1994] and more. Such programs can generate health strategies even in low-risk people.
4. *Schools can be sued if they have a program.* Response: On the contrary, staffs at schools must act in a prudent and competent fashion. We believe *not* having a program actually opens the schools to liability concerns. In the United States, for example, the Secretary's Task Force on Youth Suicide [U. S. Department of Health and Human Services, 1989] suggested that schools offer an excellent opportunity for reaching a large number of young people. The Task Force concluded that schools have an important role in addressing problems of youths. Indeed, we would go further and state that staff in schools must act as "reasonably prudent persons" [Leenaars & Wenckstern, 1996]. The decision of the U. S. Ninth Circuit Court of Appeals in *Kelson vs. the City of Springfield*, 1985, supports this view. In that case, the parents of a 14-year-old boy sued the school for negligence, complaining that the school had a duty to provide training in suicide prevention, and that the school had failed to do so. The case was deemed to be admissible in court because the court—though settlement was finally made out of court—held that a person may bring action against a school for non-prudent behavior. The issues may be more encompassing: We have consulted in a case where school administrators allowed a special "Nerd Day"—an American/Canadian euphemism for a socially awkward individual—resulting in significant abuse of a few individuals, and we believe, significant pressure in one individual, within the context of that person's

life, to contribute to his suicidal solution. That boy attempted to kill himself at the school that day, only surviving because of quick medical response. Was the behavior of the school's administrators prudent? What should be the tolerance toward violence (e. g., bullying) in schools? Should schools, as Freud already noted in 1910 [Friedman, 1967], promote health and not contribute to the violence?

Finally, are programs effective or do they actually cause contagions? The issue of contagions arises because, since Goethe [1774] published *The Sorrows of Young Werther*, there have been reports that talking about suicide causes suicide. Philips [1974] was one of the first in this century to document the impact of media reporting on suicide rates, but that finding was about sensational media stories only. It is now a well-established fact that reports in print and the electronic media about celebrities which are multi-modal, repeated, explicit, glorify the suicide on the front page, lead to an increase of suicide [Martin, 1998]. People seem to think that talking about suicide in a prevention program would bring about the same increase or even contagion. Yet, reports in the media are not equal to prevention programs. Indeed, with regard to prevention programs, there is no sound data to show that a contagion (Werther) effect was caused by an education program.

We write "sound" above because unsound research, for example, by Shaffer and his colleagues [Shaffer, Garland, Vieland, Underwood, & Busner, 1990], left the following message in the press worldwide: "School suicide prevention programs may be dangerous." The message "massaged" the world [McLuhan & Fiore, 1967]—including many school jurisdictions and politicians in the United States. Programs were banned as a result. This is unfortunate because Shaffer [1991] did not show that suicide prevention programs are in fact dangerous—all that he really showed was that a few males who had previously attempted suicide thought that their friends would not like the program. This is to be expected, because as Clark [1991] noted "psychologically impaired persons don't like to be confronted with their shortcomings in public" [p. 1]. Shaffer's study had numerous shortcomings [see Tierney & Lang, 1995], including the following: Only two programs were studied, measurement was problematic (Kappa coefficients of .22 to .51

indicated low reliability), the use of self-reports, pre- and post-testing differences. Research [e. g., Eggert, Thompson, Herting, & Nicholas, 1995; Kalafat & Elias, 1994] has, in fact, shown that prevention helps, although further study is needed.



Intervention

Intervention relates to the treatment and care of a suicidal crisis or a suicidal problem. Many people, including those in schools, can serve as life-saving agents. Nonetheless, professionally trained people, often beyond the schools, continue to play the primary roles in intervention.

Misconceptions are rife, not only about suicide, but about the treatment of suicidal people. Often there are overly simplistic solutions. In part, this is an outcome of the myth that suicide results solely from stress. Even in youths, the common consistency in suicide and suicidal behavior, however, is not the precipitating event, but complex coping patterns [Shneidman, 1985]. Suicidal youths are in unbearable pain, they are weakened and unable to cope with the demands of life [Leenaars & Wenckstern, 1994]. Focusing only on suicide as “stress” grossly underestimates the pathology that these young people face [King, 1997]—and is actually instrumental in the subsequent lack of help they receive. The truth is that these young people need long-term, multi-nature service, not short-term counseling and other naive solutions.

Although professionals (e. g., psychiatrists, psychologists) play a central role in the treatment of suicidal youths, others have an equally valuable role. Parents, in fact, have a critical contribution (if on the side of life) [Richman, 1990]. Not only should the parents be included in our interventions, but also siblings, friends, teachers, schoolmates, priests, elders, doctors—anyone who serves, directly or indirectly, to nullify the pain.

It is worth noting that the search for a singular universal simplistic response to suicide in youths is a chimera, an imaginary, nonexistent conceptual fabrication. For example, prescribing only medication as a cure-all is such a chimera. The search for a simple response is a foolish and unrealistic fancy. To illustrate, here are three examples of current “cook-book” fabrications:

1. *Suicide and suicidal behavior is easy to predict.* Response: The statistical rarity of suicide and the imperfection of the prediction instruments lead to an enormously large number of false positives, so many in fact that prediction instruments are of little use to clinicians [Maris, Berman, Maltzberger, & Yufit, 1992]. The National Institute of Mental Health (NIMH) in the United States evaluated the area of suicide prediction and assessment [Lewinsohn, Garrison, Langhinrichsen, & Marsteller, 1989] and concluded that few, if any, of the tests are useful.
2. *“No Suicide” contracts are the best tool for prevention.* Response: The use of “No Suicide” contracts has come under increasing scrutiny, namely, the simplistic written form. There may be an overreliance on them with little, if any, evidence for their utility. Frequently, written contracts are used more to comfort the therapist’s own anxiety than for their clinical value. A no-suicide contract cannot be an alternative to professional treatment. Gutheil, a forensic lawyer [Brown, Berman, Gutheil, Leenaars, & Moore, 1989] notes that, legally, contracts are meaningless. Of course, we do not mean that verbal contracting, such as “if you are suicidal, will you call me” has no utility; only their ingenuous use is wrong. The written contract is not what Drye, Goulding, and Goulding [1973] intended when they introduced the concept of contracts years ago.
3. *Peer counseling—especially because teens prefer to talk to teens—is the best mode of treatment.* Response: This is a deadly error. We are not suggesting that peer groups have no utility, only that they do not address the need of truly suicidal young people [King, 1997; Leenaars & Wenckstern, 1990a]. Peer counseling is not the same as psychotherapy. There is no research to suggest that peer counselors can provide the therapeutic care that suicidal youths need. On the other hand, a peer, teacher, guidance counselor, minister, etc., may greatly assist in identification, referral, and support. The fact that teenagers prefer to talk to teenagers is no justification for following their (often defensive) wishes. Such defense is an expression of the magnitude of the pain and their inability to cope with it.

Treatment of suicidal children and adolescents is complex and must be diverse [Leenaars, Maltzberger, & Neimeyer, 1994]. Treatment may include, but is not

limited to, the following: assessment, crisis intervention, psychotherapy, family therapy, psychopharmacotherapy, hospitalization, and, as noted at the outset, intervention in schools calls for the development of community linkage. Not all youths at risk can be treated by the limited resources in a school system, even if a school psychologist is on staff. No school alone should handle the problem of suicide in youth; just like the medical profession alone cannot address the problem. A wide array of professionals in the community is needed to address the diversity of needs of youths at risk. *There is no simple tactic.*

By definition, intervention efforts with suicidal youths involve the evaluation and management of a crisis situation. Many mental health and public health professionals, beyond school personnel, must be called on to serve as life-saving agents. Suicide risk assessment is one of the most challenging tasks [Maris, Berman, Maltsberger, & Yufit, 1992]. Intervention rests on sound assessment. Crisis intervention, whether performed by crisis-line staff or by mental health professionals in schools, should provide an immediate and informed response to a suicidal child or teen through the use of a systematic process of crisis definition and problem resolution [see, for examples, Farberow, 1967; Hoff, 1990; Leenaars, 1994; Leenaars & Wenckstern, 1994; Shneidman, 1981a].

Once a youth is no longer in an acute suicidal crisis, many psychotherapeutic approaches can be used, depending on the child's or adolescent's unique requirements [Berman & Jobes, 1991; Pfeffer, 1986; Zimmerman, Grosz, & Asnis, 1995]. Obviously, the suicidal person is in deep pain; therefore, as a rule, suicidal youths need psychotherapy to make their unbearable pain more bearable and to prompt them toward long-term solutions to life's difficulties. In choosing among the range of specialized treatment formats and approaches now available, the clinician must give special consideration to an array of patient factors: developmental age, sex, health status, cultural issues, and more.

Although suicidal pain in youths is often readily amenable to psychotherapeutic influences, medication and hospitalization should not be eschewed by any competent mental health professional in our schools with high-risk youths. Today, we know that suicide is multi-determined: Many factors, including biogenetic factors, may contribute to elevated risk. Medication

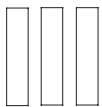
[Slaby, 1994] may be essential in some cases, as is hospitalization during periods of acute perturbation and heightened lethality [Goldblatt, 1994]. Yet, both medication and hospitalization can add complications to the treatment of suicidal youths. Although the safety needs of a suicidal patient are of utmost importance, the decision whether to admit a suicidal child or teen to the hospital is often difficult and vexing, especially in this era of decreased resources.

Regardless of the treatment model or format used, certain clinical, legal, and ethical issues confront the preventionist working with the suicidal patient [Bongar, 1994], some unique to youths in our schools. For example, if a child exhibits suicidal behavior at school, who should evaluate the risk? Or, since intervention may include more than school personnel, who is responsible for developing the necessary liaison between school and mental health facilities, as this is usually the case, when youths, to use a colloquial expression, "fall through the cracks"? Because the possibility of suicide in youths exists, practicing professionals, especially psychiatrists and psychologists, have a need for clear guidelines for assessment and intervention in schools. Legally and ethically, the professional must act in a reasonable and prudent fashion. Clinically, however, calculated risk with young people must be taken [Maltsberger, 1994], for example, when a child is discharged from the hospital and returns to the school setting. Nonetheless, school and mental health professionals must not compromise the standard of care that they provide.

Research on intervention with suicidal people is sparse [Leenaars, DeLeo, Diekstra, Goldney, Kelleher, Lester, & Nordstrom, 1997; McLeavey, Daly, Ludgate, & Murray 1994], and nonexistent in youths. Future research must include careful intervention studies, treatment research, and controlled psychotherapeutic and psychopharmacological trials [Leenaars et al., 1997].

Despite the lack of research on intervention, there is one research-supported tactic that has been shown to be useful, especially in youths [Brent, Perper, Allmen, Moritz, Wartella & Zelenah, 1991; Leenaars & Lester, 1998]: restricting the availability of lethal means. A practical application of this view is to "get the gun" in a suicidal situation where it is known that the individual intends to shoot him- or herself and has a weapon available. But the same principle applies to any method (e. g., medication). The explosive situation

of an at-risk youth needs to be defused until that person no longer feels the need for a suicidal action. Maltzberger's consultative words [Berman, 1990] on such cases may guide us in our schools and communities: "I would consult as much to avoid charges of negligence as to deal with my own anxiety. I think that any time I get into a difficult case, where I am concerned that somebody is imminently suicidal . . . I would want to be careful. It is enormously helpful to ask a colleague to help to monitor one's own judgment when in a tense, anxiety-provoking situation" [cited in Berman, 1990, p. 118]. Of course, the same approach can be used for pill proofing, media control, etc. Research [Wislar, Grossman, Kruesi, Fendrick, Franke, & Ignatowicz, 1998] shows, however, that few clinicians use such efforts in their crisis response to teens at risk. As a practical suggestion, greater emphasis on education about means restriction, in emergency wards, guidance offices, and doctors' offices is needed.



Postvention

Postvention refers to those things done after a suicide, an attempted suicide, or any other trauma has occurred [Shneidman, 1981b]. Postvention deals with the traumatic aftereffects in survivors. School systems, within the context of their communities, are an especially critical force in such endeavors with our children and teens [Centers for Disease Control, 1988].

Suicide is a trauma for the survivors, a view already held by Freud in 1917 [Freud, 1917/1974] and supported by research [e. g., Gleser, Green, & Wignet, 1981; Terr, 1979; Wilson, Smith, & Johnson, 1985]. There are many diverse, unusual traumatic events, such as serious crimes, homicide, accidents, or disasters. Suicide is equally outside the range of usual human experience, and like other traumas, it evokes "significant symptoms of distress in most people" [Leenaars, 1985; Shneidman, 1985].

Traumatic stress disorder refers to those natural behaviors and emotions that occur during a catastrophe. Figley [1985] defined posttraumatic stress disorder (PTSD) as a "set of conscious and unconscious behaviors and emotions associated with dealing with the memories of the stressors of the catastrophe and immediately afterwards," although by no means do all or

even most survivors exhibit the necessary characteristics to be labeled a disorder. PTSD is best seen as a heuristic label since it approximates the reactions in survivors of suicide and other trauma in our schools/communities [Leenaars, 1985]. In addition to the existence of a recognized stressor, symptoms in a posttraumatic reaction may include the following: reexperiencing the trauma (e. g., recurrent recollection, recurrent dreams, associations that the event is recurring); numbing of responsiveness to a reduced involvement with external world (e. g., diminished interest, detachment, constricted affect); as well as various other symptoms such as depression, grief, hyperalertness, sleep disturbance, survivor guilt, problems in memory/concentration, avoidance of events that evoke recall, intensification of symptoms by events that symbolize events, to name a few [American Psychiatric Association, 1980; Freud, 1926/1979; Janoff-Bulman, 1985].

Adjusting to a suicide and any other trauma is remarkably difficult, with possible positive and negative responses [Freud, 1939/1974]. Freud saw remembering, repeating, and reexperiencing as positive, and forgetting, avoidance, phobia, and inhibition as negative. Negative reactions are regrettably all too common in many victims after a suicide (and other traumas), even in the adults who are supposed to guide our youngsters, such as principals and psychologists. A common response is simply to deny it: "Don't talk about it; after all, talking about suicide causes suicide." We firmly believe, as has been so well documented with Vietnam victims, that this approach only exacerbates the trauma. However, as Wilson, Smith, and Johnson [1985] have pointed out, it is important for us to see that the victims of a suicide may be caught in a no-win cycle of events, noting the following:

To talk about the powerful and overwhelming trauma means risking further stigmatization; the failure to discuss the traumatic episode increases the need for defensive avoidance and thus increases the probability of depression alternating with cycles of intensive imagery and other symptoms of PTSD. [p. 169]

It should be noted that PTSD was initially intended as a description of a reaction to trauma for adults [APA, 1980]; however, Eth and Pynoos [1985] presented convincing arguments for applying PTSD to children and adolescents as well. There are, in fact, remarkable

commonalities in how children respond to various unusual traumatic events [Leenaars & Wenckstern, 1990b]. In response to such observations, the APA [1987] has clarified its definition to include children and teens.

The response to suicide and trauma in schools must be complex. Postvention is multifaceted and takes time—from several months to an entire lifetime, but certainly more than three or six hours. PTSD work is a great challenge. As space is limited here, let us point to more comprehensive discussions of the strategies for postvention presented elsewhere [Leenaars, 1985; Leenaars & Wenckstern, 1990b, 1996; Wenckstern & Leenaars, 1990, 1993]. Essential aspects of such programs include, at least, consultation, crisis intervention, community linkage, assessment and counseling, education, liaison with the media, and follow-up. These approaches should serve to defuse the aftershocks and not add to the hysteria [Callahan, 1996; Goldney & Berman, 1996].

Misconceptions are equally common in postvention as in prevention and intervention. Let us begin with the most common fabrication today:

1. *Postvention doesn't work.* Response: To illustrate that this is a myth, let us cite an example from the professional literature. Hazell and Lewin's [1993] banal platitude was: *Postvention doesn't work.* Hazell and Lewin [1993] sought to evaluate postvention by examining suicide cases in two schools, equating postvention with group counseling (i. e., debriefing). Yet, postvention does not simply equal group counseling. Group counseling can be one strategy of postvention, although we strongly believe that individual work is a more appropriate primary mode of treatment for individuals at risk for PTSD, depression, suicide, and other maladaptive reactions. They evaluated only increase in risk for suicide; however, contagion is only one possible aftershock. They developed a risk index for suicide, which itself is questionable according to a review by the National Institute of Mental Health [Lewinsohn, Garrison, Langhinrichsen, & Marsteller, 1989] to measure the aftershocks. Group counseling, in the situations examined by Hazell and Lewin, also presents problems because it consisted of seeing 20 to 30 children in a group for 90 minutes. Not only is this not postvention, it is not even group therapy [Yalom, 1975]. Indeed, we believe that it is probably better to

do nothing after a suicide than to debrief youths for 90 minutes. Callahan [1996] has, in fact, provided a clear clinical example where such an approach actually added to the hysteria following a suicide. Yet, Hazell and Lewin [1993] erroneously concluded that postvention does not work, and that schools should not implement such programs. All they showed, however, is that a few hours of group sessions, called "debriefing," should not be equated with postvention—an important finding given confusion about this issue even among practitioners [e. g., Paul, 1995].

Postvention must be based on sound research. The same issue, as we saw, has arisen in the field of prevention (i. e., education) in the schools about suicide and death. Conclusions are drawn from methodologically poor and limited studies. We have encouraged sound research in the field since the early 1980s [Leenaars, 1985], echoing a call 90 years ago [Friedman, 1910/1967].

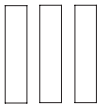
2. "*Postvention is the same as grief counseling.*" Response: We believe that persons holding this view have gone awry. Postvention may include grief counseling, but the two are not equivalent. A response to a trauma is more than only counseling, whether focused on grief or other behavior.
3. Other platitudes—in short—include: "*Postvention is debriefing.*" "*Don't talk about the trauma, it will go away.*" "*Don't worry—we will save you.*" "*All people respond the same—we will tell you how they will react.*" "*Postvention is the same as prevention.*"

Finally, are postvention efforts effective? There is a need for more data to support the practice of postvention; yet, clinical understanding at this time already dictates that we do so. Should we have done nothing after the homicide-suicide in Carrollton, Georgia? At Central High in Carrollton on January 8, 1999, Jeff Miller shot his girlfriend, Andrea Garrett, and then himself, in what authorities called a suicide pact. A panic occurred subsequently at the school. Should we not assist the students at Central High? To cite other examples, should we have done nothing after the massacres in Dunblane, Scotland, and at Columbine High School in Littleton, Colorado?

There are some studies that show that postvention has value, although there is a general lack of systematic research of programs that address PTSD [Deahl,

Gillham, Thomas, Searl, & Srinivasan, 1995; Raphael, Meldrum, & McFarlane, 1995], and none about comprehensive efforts in schools. The research that questions such procedures has been limited to debriefing [e. g., Deahl et al., 1995], something that we and others [e. g., Callahan, 1996] have questioned. Despite this state of the research, we need to ask now what we should do in schools/communities once a trauma occurs [Goldney & Berman, 1996]. This is as true about postvention as it is about prevention and intervention in schools/communities.

As an endnote to this section, Wenckstern and Leenaars [1990] presented a case in which no program was allowed by a principal causing aftershocks to occur, i. e., a contagion followed a suicide at a school. The principal simply denied the initial event stating, "We don't want to put ideas in their heads." This event led us to conclude that a principal or school administrator simply should not be allowed to make that decision alone. These are decisions for mental health and public health professionals. We need prudent policies and procedures to address suicide and trauma in our schools and communities.



Prologue

It may seem odd to call our concluding remarks a prologue, which usually means an event serving as an introduction. Our paper can be only that: an introduction to the complex subject of suicide prevention—prevention, intervention, and postvention—in schools/communities. It is a prologue to future endeavors.

Suicide is a major mental health problem and public health problem in our youths. More study and discussion are needed. What are the critical issues in prevention in schools, what are the fabrications? Are our suggestions only myths? There are many other issues. At this time we must ask at least the following questions:

- Do we agree that suicide is a problem?
- Are the school and community supportive of doing something about the problem?
- Can we agree on the minimal strategies in prevention, intervention, and postvention?
- What are the ideal approaches?
- What should be the standard of care in schools? Are

they the same, different, and/or unique than in other settings (e. g., hospitals)?

- What community linkages are needed—minimal and ideal—with schools?
- What a priori system entry issues must be addressed?
- Should prevention efforts be mandatory?
- How do we evaluate the cost-effective component (if this is even important) of our education programs?
- How can we increase the ability to assess suicide risk?
- What instructions, skills, etc., are needed by school personnel to begin to screen people at risk for suicide (or violence)?
- What interventions are effective with youth? Do we have any data that counseling helps?
- How can we utilize means restriction to assist more?
- What are the essential features of postvention in schools? At the very least, it appears to include the following: consultation, crisis intervention, community linkage, assessment and counseling, education, liaison with media and follow-up. What aspects are minimal? Ideal?
- How does postvention in schools differ from grief counseling? How is it similar? How do we evaluate our prevention efforts?
- Finally, are there any suicidogenic effects in our prevention efforts? If so, how are they measured? Addressed?

Research is needed on the above topics. At the least, the following need to be made explicit in future study:

Theory stated; the purpose made explicit (immediate; long-term); change(s) expected; more specification about goals; more detailed description of programs, tactics, etc.; what should be measured; standardization of measurement instruments; target(s) specified; design clearly outlined; analysis explicated; and comparability of strategies across sites.

A clarity of theory in suicide prevention in youths, often lacking, will be essential. The whole field of suicidology, of course, is in need of reflection. For example, Goldney [1998] noted that, given the very nature of our subject (e. g., low base rate), we need to be creative and "approach the challenge of suicide prevention with innovative research ideas and methodologies to demonstrate the effectiveness or otherwise of our

programmes" [p. 336–337]. A reconvening of the 1910 meeting [Friedman, 1910/1967] by an international panel is urgently needed. At this time, we strongly advocate a comprehensive program in schools and the communities to address suicide in youths.

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Antoon A Leenaars, PhD, CPsych, is a psychologist in private practice in Windsor, Canada, and a Researcher at Leiden University, The Netherlands. He is Editor-in-Chief of Archives of Suicide Research and has served as President of both the American Association of Suicidology (AAS) and the Canadian Association for Suicide Prevention (CASP). Address correspondence to Antoon A Leenaars, PhD, CPsych, 880 Ouellette Ave., Suite 7–806, Windsor, Ontario, Canada N9A 1C7 (Tel. +1 519 253-9377, Fax +1 519 253-8486, E-mail draalee@wincom.net).

Susanne Wenckstern, MA, CPsychAssoc, is a psychological associate with the Greater Essex County District School Board, Windsor, Ontario, Canada. She has been a Board member of the Canadian Association for Suicide Prevention, and is co-editor (with A. Leenaars) of the book Suicide Prevention in Schools.