

*Handbook For
Crisis Intervention
and
Suicide Prevention*

**ROCHESTER COMMUNITY AND
TECHNICAL COLLEGE
COUNSELING CENTER**

Rochester Community and Technical College 285-7260

Crisis Intervention and Suicide Prevention

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Preface

“Suicide is not a neutral word, it is not a neutral behavior. As a word it evokes apprehension and creates a desire to avoid or detach oneself from discussion. As a behavior it evokes powerful emotional reactions regardless of the outcome. Fear, anxiety, disbelief and anger are but a few of the emotions that create an atmosphere which impedes a discussion or involvement in the issues of suicide. Such attitudes and actions of avoidance and indifference may be alleviated and replaced with positive actions and reactions.”

THIS GUIDE IS DESIGNED TO ASSIST EDUCATORS/STAFF MEMBERS IN BECOMING MORE AWARE AND KNOWLEDGEABLE OF THE SYMPTOMS, FACTS AND APPROPRIATE RESPONSES TO THE ISSUES SURROUNDING SUICIDE. IT IS TO BE USED BY EDUCATORS/STAFF MEMBERS AS A RESOURCE IN ASSISTING STUDENTS TO RECEIVE THE APPROPRIATE AND NECESSARY HELP AND INTERVENTION.

THIS CRISIS INTERVENTION AND SUICIDE PREVENTION GUIDE IS NOT INTENDED TO BE USED AS A SUBSTITUTE FOR OBTAINING SKILLED MENTAL HEALTH SERVICES.

“Suicide is a traumatic event for the individual and for all of those persons who have some connection with him/her. Shniedman has stated: “Human understanding is the most effective weapon against suicide. The greatest need is to deepen the awareness and sensitivity of people to others.”

Let this be the beginning of greater awareness and sensitivity by all of the College community.

Acknowledgements:

In the spirit of collaboration this booklet has been revised to include all University Center Rochester campuses. This project began with the Community Counselor’s ad hoc committee on suicide: Tom Carey, Maureen Rochford, Kathy Schur, Sheila Kimble, John Jefferson, Audrey Lidke, and John Klippstein.

Audrey Lidke, Counselor 1998 (Updated 2008)
Rochester Community and Technical College
Counseling Center

POLICY

STATEMENT ON STRESS/DEPRESSION/SUICIDE

Stress, depression and suicide are recognized as critical problems for learners, the education system and the greater community. Students are at risk in the learning process when they are depressed, under stress, or suicidal.

The Rochester post-secondary institutions are committed to leadership and action toward an appropriate college response to persons at risk, and to a college-wide plan which identifies and accesses resources for use in times of crisis.

HOW STUDENTS REACT TO STRESS, DEPRESSION, GRIEF AND SUICIDE

“Mental health is not the absence of problems—it is dealing effectively with life’s problems.” Every person will have bad days, weeks or months. However, the person who reacts well to problems will have a more positive mental health. A breakup with a girlfriend, boyfriend, feared pregnancy, a divorce (or parents divorcing), moving, financial problems, a death of someone near to us, drugs or trouble with the law are all examples of problems we have as well as the students we teach experience.

Basically, there are three ways to react to stress and problems:

1. **POSITIVE ACTIONS**- asking for help, talking about it finding options (Not always solutions), working for change, etc.
2. **ACTING OUT**- rage, abuse of some kind, fighting, using drugs, etc.
3. **ISOLATING**-withdrawal from activities and friends, excessive sleeping, daydreaming, etc.

A sizeable number of students have many of the “positive action skills” necessary to deal with stress and problems. They may have a couple of close friends or family support available to them. Some are able to ask for help and/or generate new options for he problem.

Unfortunately, a sizeable number of people “act out” when problems arise. Acting out by being rageful or abusive ironically brings temporary relief to problems. Unfortunately, this type of approach to problems can escalate conflict and inflict much harm to the student and those close to him or her. Abusing drugs-including alcohol-drinking and driving, verbal abuse and physical abuse just escalate problems and could lead to accidents or even suicides.

“Isolating” can also be destructive. Turning off or tuning out support, care and help is destructive to self and those close to that person. Stress, depression and grief intensifies with this kind of reaction to problems.

At any given moment one in 20 Americans is suffering from depression (N.I.M.H., 1988). Many experts believe depression is a disease that happens to people. Sometimes it follows an unhappy event. Sometimes it is the result of a biochemical imbalance and comes when everything is going right. For some students and staff members, their social and life skills are not enough to improve their mental health. Students who are depressed may need medication and/or psychotherapy. Unfortunately, only one in three with depressive disorders receives any treatment.

MYTHS AND FACTS ABOUT SUICIDE

An encounter with a suicidal person is always a deeply emotional experience. There is a fear of not knowing what to do or of doing the wrong thing. However, the basic empathic “I CARE ABOUT YOU” indicates that there is hope and help, two key ingredients in the intervention process. MISINFORMATION often prevents individuals from becoming involved for fear of making a situation worse. There are many myths about suicide which deter individuals from becoming involved. What are the myths and what are the facts?

MYTH: PEOPLE WHO TALK ABOUT SUICIDE RARELY ATTEMPT OR COMMIT SUICIDE.

FACT: Approximately 70-75% of people who attempt or commit suicide have given some verbal or non-verbal clue to their intentions.

MYTH: THE TENDENCY TOWARD SUICIDE IS INHERITED.

FACT: Suicide has no characteristic genetic quality. Suicidal patterns in a family are a result of other factors and may result from a belief in the myth which facilitates suicidal actions.

MYTH: THE SUICIDAL PERSON WANTS TO DIE.

FACT: Suicidal persons often reveal considerable ambivalence about living vs. dying and frequently call for help before and after a suicide attempt.

MYTH: ALL SUICIDAL PERSONS ARE DEPRESSED.

FACT: Depression is often associated with suicidal feelings but not all persons who attempt or commit suicide are depressed. A number of other emotional factors may be involved.

MYTH: ASKING, “ARE YOU THINKING ABOUT COMMITTING SUICIDE?” WILL LEAD THE PERSON TO SUICIDE ATTEMPT.

FACT: Asking a direct, caring question will often minimize the anxiety and act as deterrent to suicidal behavior.

MYTH: SUICIDE IS MORE COMMON IN LOWER SOCIOECONOMIC GROUPS.

FACT: Suicide crosses all socioeconomic group boundaries.

MYTH: SUICIDAL PERSONS RARELY SEEK MEDICAL HELP.

FACT: Studies of persons who have committed suicide indicate that 50% have sought medical help within six months of their action.

MYTH: SUICIDE AND ATTEMPTED SUICIDE ARE THE SAME CLASS OF BEHAVIOR.

FACT: Attempted suicide is a behavior with its own characteristics, not just a failed suicide. It signals a disturbed situation.

MYTH: IMPROVEMENT IN A SUICIDAL PERSON MEANS THE DANGER IS OVER.

FACT: There is a significant danger within the first 90 days after a suicidal person is released from hospitalization.

MYTH: ONLY A MENTAL HEALTH PROFESSIONAL CAN PREVENT SUICIDE.

FACT: Suicide prevention by lay persons and centers has been an important, significant part of suicide prevention activities.

(Facts and Myths adapted from “The Issue is Suicide”
Ralph L.V. Rickgran, University of Minnesota)

IDENTIFYING HIGH RISK STUDENTS

Suicide is now the eighth leading cause of death in the United States. It is the second leading cause of death among the 15 to 24-year-old age group. Every year some 35,000 Americans are officially reported as having committed suicide. According to educated estimates, however, the true number of suicides may be as high as 100,000 a year. There may be as many as 8 to 10 suicide attempts for every “successful” suicide. More than 5 million people now living in the United States have tried to kill themselves. The number of suicides among teenagers and young adults has increased dramatically in the last 20 years. According to the Minnesota Student Survey (1989) 27% of young females and 21% of young males have had thoughts of suicide within the past month. The survey stated further that 16% of young females and 8% of young males have attempted suicide.

(For everyone’s understanding, it is important to identify the following standard terms and definitions used in suicide prevention, intervention and postvention.)

ATTEMPTED SUICIDE: A very serious, self-destructive act which could easily result in death were it not for fortuitous circumstances beyond the person’s control.

SUICIDAL GESTURE: An act that is indicative of self-destructiveness, but the level of lethality is so low that it could not cause death.

SUICIDE THREAT: Saying or doing something that reveals a self-destructive desire. Because it is sometimes exceedingly difficult to distinguish between serious and idle threats, always respond as if the threat is quite serious, i.e. writing, drawing, or speaking about suicide.

SUICIDE IDEATION: Having thoughts about killing yourself. (Many people have had thoughts at one time or another in their lives.)

There is not a primary pattern of personality that typifies someone who is suicidal. However, certain kinds of risk factors coupled with identified “Acting Out” behaviors warrant attention and action.

CLUES TO SUICIDAL IDEATION AND ACTION

BEHAVIORAL

Noticeable changes in patterns of appetite, sleep (disturbance), work, sexual, academic, physical appearance, alcohol and other chemical usage, social activities, weight (gain or loss).
Lack of energy, lethargy, fatigue.
Loss of pleasure in usual activities.
Decreased concentration and lack of interest.
Hyperactivity, restlessness.
Somatic complaints.
Withdrawal.
Frequent, unexplained, irrational changes in behavior.
Impulsiveness and recklessness.
Aggressiveness.
Giving away favorite or prized possessions (“living will”)
Making final arrangements (will, insurance, funeral plans.)
Saying “goodbyes.”

EMOTIONAL

Withdrawal, sulkiness.
Anxiety.
Crying spells, tearfulness, sadness.
Nervousness.
Pronounced mood swings.
Feelings of helplessness and hopelessness.
Feelings of loss.
Feeling of isolation, loneliness, alienation.
Depression.
Sudden happiness following depression.
Low self-esteem, unreal expectations of self.
Despondency.
Guilt, remorse, self-reproachment.

STATEMENTS

“I won’t be around much longer.”
“___ would be better off without me.”
“I want to die.”
“I’m going to end it all.”
“Nobody would miss me if -----.”
“Who would care?”
“They’ll be sorry when I am gone.”
“I just want to lay down and sleep forever.”
“It won’t be long before the pain is gone.”
“Did you ever wonder what it would feel like to be dead?”
“I just can’t take it anymore.”
“I’m going to commit suicide.”

DEVELOPING AND IMPLEMENTING SUICIDE PREVENTION STRATEGIES

The following list of possible subject areas one could choose in developing and implementing Suicide Prevention Strategies in the classroom/workplace.

Teach that there is a need for suicide prevention.

Teach that research does not support the belief that it is dangerous to talk in a factual way about suicide.

Talk to your students about depression.

Teach that depression can be recognized.

DEPRESSION HAS SYMPTOMS AND SOME OF THESE MAY BE:

Sadness.

Fluctuation between apathy and talkativeness.

Anger and rage, verbal sarcasm and attack.

Overreaction to criticism.

Guilt.

Feelings of being unable to satisfy ideals.

Poor self-esteem.

Loss of confidence.

Feeling of helplessness or hopelessness.

Intense ambivalence between dependence and independence.

Feelings of emptiness in life.

Restlessness and agitation.

Pessimism about the future.

Death wishes, suicidal thoughts, plans or attempts.

Rebellious refusal to work in class or cooperate in general.

Decrease in academic performance.

Sleep disturbances.

Increased or decreased appetite, severe weight gain or loss.

SYMPTOMS IN ADULTS

Persistent sad, anxious, or “empty” mood.

Feelings of hopelessness, pessimism.

Feelings of guilt, worthlessness.

Loss of interest or pleasure in ordinary activities, including sex.

Sleep disturbances (sleeping too much or too little).

Eating disturbances (loss of appetite and/or weight gain or loss).

Decreased energy, fatigue.

Thoughts of death or suicide.

Restlessness, irritability, difficulty concentrating, remembering, making decisions.

If four of these symptoms persist for two weeks or more a doctor should be consulted. It is important to stress that unhappiness is normal.. We all have “ups” and “downs”. Intensity and duration are the two clues to distinguishing normal sadness from depression.

Teach that depression can be effectively treated.

Teach that medication is sometimes necessary,--and this is OK.

Teach that there is much needless suffering because people do not recognize depression and seek treatment.

Even though time and effort is needed developing suicide prevention strategies these programs can provide support and caring for at-risk students. In addition, the faculty or staff members can receive much support and reward for taking the time to improve the community college climate.

(Adapted form “Why Talk to Your Students About Depression,”
Minnesota Mental Health Association, 1989)

In some instances severe stress overwhelms the capacity to cope and suicide becomes a possibility.

Life Events that Might Produce Feelings of Intolerable Stress

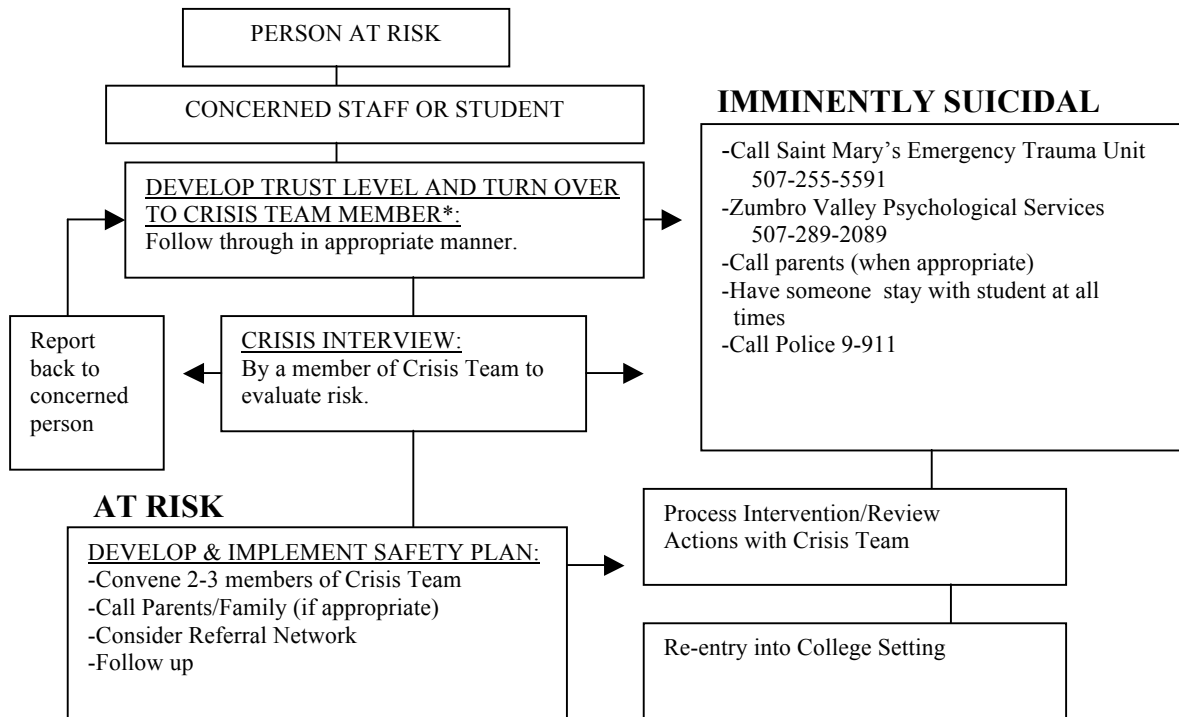
Suicide of Parent, Spouse, or Loved One	Arrest
Death of Spouse or Child	Legal Involvement
Death of Parent	Victim of Crime
Death of Friend	Witnessing Violent Event
Sexual Abuse or Assault	Running away from Home
Physical Abuse	Failing Grades
Loss of Health	Homosexuality
Serious Illness in Family	College Rejections
Dependency on Drugs or Alcohol- Self/Family/Loved One	Moving to New School
Divorce or Separation from Spouse	Financial Setbacks
Divorce or Separation of Parent	Retirement
Remarriage of Parent	Retirement

(Taken from Suicide Intervention Handbook, Living Works, 1997)

SUICIDE INTERVENTION MODEL

WHEN A STUDENT SEEMS TO BE AT RISK

- A. What should you do if you are seriously concerned about a student’s emotional state or if the student starts talking about suicide?
1. Give emotional support. (“You did the right thing by coming in to talk.”)
 2. Confirm trust level (make sure you are connected to their thoughts and feelings) by end of discussion.
 - a. Listen carefully! Check out what you have heard. This indicates that you not only want to understand what is being said, but also that you want to understand accurately what is said. It shows you care!
 - b. Try to remain calm and keep a positive attitude.
 3. Express concern.
 4. Establish a “bridge” to Crisis Team members and follow-up appropriately. (Stay in touch with a student during and after crisis as advised by Crisis Team.)



*See page 11.

CRISIS TEAM MEMBERS AND QUICK REFERENCE GUIDE

Contact a Crisis Team Member if:

- ^ a student seems to be at risk.
- ^ if you are seriously concerned about a student's emotional state
- ^ if the student starts talking about suicide

THESE SITUATIONS REQUIRE **IMMEDIATE ATTENTION!**

CRISIS TEAM MEMBERS:

Bob Ekstam, Counselor	SS136	285-7263
Janet Finlayson, Counselor	SS 143	529-2728
Jim Kehoe, Counselor	SS142	285-7231
Audrey Lidke, Counselor	SS137	285-7469
Gregg Wright, Counselor	SS141	280-3515

CRISIS REFERRAL RESOURCES:

St. Mary's Emergency Trauma Unit 1216 2 nd St SW Rochester MN 55902	255-5591
Zumbro Valley Mental Health Center-Corrections & Referral Unit 2116 Campus Drive SE Rochester MN 55904	281-6248
Law Enforcement Center 101 4 th St SE Rochester MN 55904	285-8580 (non-emergency dispatch) or 9-111
Olmsted County Department of Social Services Government Center 2116 Campus Drive SE Rochester MN 55904	507-328-6400
Zumbro Valley Psychological Services 1932 Viking Dr NW Rochester MN 55901	289-2089
Women's Shelter	285-1010
Victim's Services	328-7270

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Bongar, 1992

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Poland, 1989

Suicide Intervention Handbook
Living Works, 1994

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The Suicidal Patient: Clinical and Legal Standards of Care
Bongar, 1991

WEB SITES:

www.SAVE@winternet.com
www.unh.edu/counseling-center/suicide.html
www.gu.edu.au/gwis/aisrap/suicide.html

