Suicide prevention has not been adequately addressed since the “global” mortality rate for suicide for the year 2000 was 16 per 100,000, which averages one death every 40 seconds somewhere in the world. This article examines brief clinical and community-based interventions for the prevention of youth suicide. Among the more commonly advocated clinical methods for at-risk adolescents are cognitive behavioral treatments, interpersonal psychotherapy, and psychopharmacological interventions. Community-based prevention methods consist of 24-hour crisis centers and hotlines, method restriction, indirect case-finding, direct case-finding, media communications, postvention programs, parenting programs, and cultural programs for minority groups. It is concluded that a number of promising primary and secondary prevention interventions now exist but that there is a need for more carefully controlled evaluations into their effectiveness. [Brief Treatment and Crisis Intervention 2:217–231 (2002)]

KEY WORDS: youth suicide, brief clinical interventions, community interventions, cognitive behavioral treatments, psychotherapy, psychopharmacological interventions, crisis centers and hotlines, case-finding.

According to the World Health Organization (WHO), the prevention of suicide has not been adequately addressed due both to a lack of awareness of suicide as a major problem and the taboo in many societies to discuss it openly (www.who.int/mental.health). In the year 2000, it was estimated that approximately 1 million people died from suicide, a “global” mortality rate of 16 per 100,000, averaging one death every 40 seconds. Every day, approximately 1,500 Americans attempt suicide, while approximately 86 of them succeed, making the suicide toll in 1994 over 31,000 (Henkel, 2001; Metha, Weber, & Webb, 1998). In 1994, 2,200 youths under 20 years of age committed suicide in the United States, the frequency increasing with age through the teenage years (Shaffer et al., 2001). The United States ranks ninth of the 24 countries on which the WHO reported in 1992 for suicides in the 15–24 year age range; Australia
ranks 4th, and the United Kingdom 17th (ABS, 2001; Martin, 1998). Internationally, the overall suicide rate has remained relatively constant over the past 80 years, but the rate for males aged 15–34 has increased significantly over the last 30 years along with a concurrent decline in the 45+ age group (ABS, 2001; Diekstra, Kienhorst, & de Wilde, 1995; Lynskey, Degenhardt, & Hall, 2000; Rutter and Smith, 1995). Suicide now ranks among the top two or three leading causes of death for those aged 15–34 years (Diekstra et al., 1995). Moreover, it is widely believed that suicide is underreported (Diekstra, 1995; Goldney, 1991). For a death to be classified as suicide, it must be recognized as due to other than natural causes, and it needs “to be established by coronial inquiry that death results from a deliberate act of the deceased with the intention of ending his/her own life” (www.abs.gov.au/ausstats). Although suicide is a statistically rare event (ABS, 2001; Davies, Naik, & Lee, 2001; Martin, Roeger, Dadds, & Allison, 1997; Shaffer et al., 2001; Turley, 2000), recent research has shown it to be far more serious than homicide in resource and impact terms (Metha et al., 1998; Pritchard, 1995).

Suicidal behaviors do not occur at random. They happen within a context of community problems and psychological, family, and relationship dysfunction, compounded in many cases by a recent significant loss (Martin et al., 1997). The factors predisposing people to suicide include biological, psychological, and social factors (Williams, 1997). The overwhelming proportion of adolescents who commit suicide (over 90% in the U.S.) suffer from an associated psychotic disorder at the time of their death (Kotila, 1989; Runeson, 1989; Shaffer et al., 2001). Suicide results most often from an accumulation of risk factors, which lead to complex and compounding vulnerabilities (CDHAC, 2000). Current research evidence suggests that the strongest risk factors for youth suicide are mental health difficulties, drug or alcohol misuse, prior suicidal behavior, occurrence of suicides among family or close friends, antisocial behaviors, and a history of psychopathology (Beautrais, 2000; Martin et al., 1997; Rutter and Smith, 1995). A possible further contributing factor is that the lowering of the age of puberty has caused an increased disjunction between biological, psychological, and social development, which may add to the stresses that overtax the coping mechanisms of young people and their families (Diekstra et al., 1995).

Epidemiological studies across all age groups also generally show a relationship between suicide or suicidal behaviors and socioeconomic disadvantage, including limited educational achievement, homelessness, unemployment, economic dependence, and contact with the police or the criminal justice system (NACYP, 2000). To these can be added social isolation, rural or remote location, rejection of gender preference, major losses of all kinds, relationship experiences including abuse or neglect, finding life’s activities meaningless, or waiting to die (Cantor and Neulinger, 2000; Curriculum Review, 2001; Haight and Hendrix, 1998; Hendin, Maltsberger, Lipschitz, Pollinger Hass, & Kyle, 2001; Hoskinson, 2000; Rutter and Smith, 1995; Vajda and Steinbeck, 2000). Many of these risk factors are the same for both sexes (Shaffer et al., 1996, 2001; Shaffi, Carrigan, Whittinghill, & Derrick, 1985). The cultural or ethnic background of a person may also be a factor propelling a person toward a final decision if any of these other risk factors are present. In relation to biological factors, it has also been suggested that serotonin irregularities make it more difficult for a suicidal individual to control his or her impulses (Shaffer et al., 2001). One of the factors that has been found in the United Kingdom to identify individuals with a genuinely high risk of suicide is readmission to hospital of those with severe mental illness (Davies et al., 2001). Zubrick and Silburn (1996) similarly contend in Australia that presentation at hospital represents the single
best opportunity for intervention with the suicidal individual. No other group is at higher risk of suicide than those who have survived an attempt.

In summary, the three major risk factors for suicide are considered to be mental health difficulties (including depression), drug and/or alcohol misuse, and previous suicide attempts. The difficulty remains of identifying those within this group who may go on to actually commit suicide. It is now something of a cliché that many of those who commit suicide do not want to die; rather, they cannot face living (Alvarez, 1971). Many have mixed feelings about living and dying (Goldney, 1991) and merely want to escape pain (CDHAC, 2000). In endeavoring to intervene and prevent suicidal behavior, a major priority is to identify those at greatest risk (Martin, 1998). Once this identification has been made, the hope is that intervention might occur in a way that leads to a positive engagement with those at risk. This article seeks to identify brief intervention strategies for suicide prevention. Some of these strategies involve intensive one-on-one therapies by trained professionals lasting a number of sessions. Others are geared at social groupings within the population, and involve brief training strategies for people not specifically trained in the area of therapy or suicide. With intensive clinical therapies, clients tend to come to where the therapy is being offered by a specialist, either to a hospital or clinic setting. By contrast, the second form of strategy often involves meetings between prevention workers and community groups in nonclinical settings. All of the strategies reviewed below can be classified as “brief” because they are offered over a limited period of time, never longer than 6 months.

**Brief Clinical Interventions**

It has been convincingly demonstrated that brief intervention strategies utilized by psychotherapists are equally as effective as longer-term strategies (Shaffer et al., 2001). These can be conducted on a one-on-one basis or in group settings, by trained psychotherapists. Different forms of psychotherapy and psychopharmacology are available to treat suicidal behavior and should be tailored to meet the particular client’s needs. Psychotherapeutic techniques aim to decrease the intolerable feelings and thoughts of worthlessness, desperation, or a hopeless inability to change or find a solution to frustrating circumstances (Shaffer et al., 2001). Proven interventions to prevent recurrence of depression exist, for example, cognitive behavioral therapy and interpersonal psychotherapy (Davies et al., 2001). It is important that a therapeutic alliance be established in order that the client is prepared to continue treatment. Treatment compliance may be improved by offering definite, closely spaced follow-up appointments, being flexible with appointments if a crisis should arise, and reminding the client of the next appointment by phone or mail (Shaffer et al., 2001). Clinicians should be prepared to admit as inpatients suicide attempters who express a persistent wish to die and have a clearly abnormal state. “Inpatient treatment should continue until their mental state or level of suicidality has stabilised” (Shaffer et al., 2001, p. 27). The client should then only be discharged when a responsible third-party is able to provide adequate supervision and support.

Among the most commonly advocated brief clinical interventions, whether offered on an inpatient or outpatient basis are cognitive behavioral treatments, interpersonal psychotherapy and psychopharmacological treatments.

**Cognitive Behavioral Treatments**

Cognitive approaches to suicide focus on the “automatic thoughts” that influence emotions and behaviors. The fundamental idea is that the information we absorb is filtered through belief
systems that trigger thoughts about the meaning of the situation or event at hand. We learn to cope and adapt to our environment based on our belief systems (Beck & Weishaar, 1989; Weishaar & Beck, 1990), sometimes in healthy ways and at other times in ways that are troublesome or self-destructive.

Suicidal clients often have a negative view of themselves resulting in internal attributions (self-blame) when aversive events occur and external attributions (e.g., luck) when positive events occur (Freeman & Reinecke, 1993). Suicidal client expectations of the future are similarly problematic (Hughes & Neimeyer, 1990). This conceptualization of suicidal ideation as faulty thinking allows for the development of a set of practical techniques aimed at encouraging clients to reassess the underlying beliefs responsible for self-defeating automatic thoughts.

Cognitive-behavioral treatment commonly begins by examining the client’s motives for suicide. The establishment of motive allows the counselor to help clients consider whether suicide is likely to be the most successful method for obtaining their goals. The most fundamental technique for challenging the behaviors and automatic thoughts of suicidal clients involves training the clients themselves to question the evidence for negative automatic thoughts when they arise. Clients are asked to examine logically their beliefs and to adjust those beliefs when they are unsupportable. Consistent with this technique, clients are also taught self-instruction to stop or reduce ruminating about failures when such thoughts arise and to practice more positive automatic thoughts.

Brent and Poling (1997; as mentioned in Shaffer et al., 2001) have developed a structured treatment program based on these principles, which comprises 12 to 16 weekly sessions followed by a 6-month booster phase, along with a psycho-educational manual about mood disorders and their treatment (also NACYSP, 2000). A similar manual-driven, cognitive-behavioral program known as dialectical behavioral therapy (DBT) developed by Linehan, Heard, and Armstrong (1994) has reported promising results with particularly difficult client populations, such as clients diagnosed with borderline personality disorder (BPD).

DBT involves developing problem-oriented strategies to enable the suicidal young person to make more balanced decisions. DBT is based on a biosocial theory that was originally developed for adult chronically parasuicidal women diagnosed with BPD (Simpson et al, 1988). The procedure focuses on four characteristic problem areas often found among multiproblem patients: (a) confusion about self, (b) impulsivity, (c) emotional instability, and (d) interpersonal problems. When applied to suicidal adolescents DBT consists of 12 concomitant weekly individual and group therapy sessions. A primary focus and dialectic of the treatment is the emphasis on balancing change and acceptance. Hence, the therapist selectively applies problem-oriented change strategies balanced with acceptance strategies. DBT employs four behavioral skills modules aimed at increasing adaptive behaviors while simultaneously reducing maladaptive behaviors. The four skill modules include mindfulness (attention to one’s experience), distress tolerance, emotion-regulation, and interpersonal effectiveness skills. DBT has shown promising results in reducing parasuicide, medical risk of parasuicides, number of hospital days, dropout from treatment, and anger (Shearin & Lineham, 1994).

Interpersonal Psychotherapy

As the term suggests, interpersonal psychotherapy focuses on problems in suicidal clients’ interpersonal relationships and successful treatments have been administered on a weekly basis for 12 weeks along with frequent telephone contacts (Shaffer et al., 2001). A procedure known as Interpersonal Psychotherapy for Depressed
Adolescents (IPT-A) is a brief, specified psychotherapy originally developed by Klerman, Weissman, Rounsaville, and Chevron (1984) for depressed adult outpatients and adapted for adolescents. The adaptation for adolescents addresses common adolescent developmental issues, such as separation from parents, exploration of authority in relationship to parents, development of dyadic interpersonal relationships, initial experience with the death of relative or friend, and peer pressure. Mufson, Weissman, Moreau, and Garfinkel (1999) recently reported on the use of IPT-A in a randomized, controlled clinical trial in which experimental clients were compared with adolescents who were treated only with clinical monitoring. Experimental clients were seen weekly for 12 weeks with once weekly additional telephone contact between therapist and patient during the first 4 weeks of treatment. The adolescents who received interpersonal psychotherapy reported significantly greater decreases in depressive symptoms and greater improvement in social functioning and social problem-solving skills.

**Psychopharmacological Interventions**

Lithium treatment has been found to reduce eight-fold the recurrence of suicide attempts in adults with bipolar, or other major affective, disorders (NACYSP, 2000; Shaffer et al., 2001). Mood stabilizers and antidepressants can be used successfully, although their efficacy in terms of reducing the risk of suicide has not yet been empirically demonstrated. Selective serotonin reuptake inhibitors (SSRIs) have also been shown to reduce suicidal ideation in adults, but are yet to be verified with adolescents. For people with schizophrenia and schizoaffective disorders, clozapine therapy has been shown to reduce risk of suicide from five times that of the general population to a rate close to the general population (NACYSP, 2000). All pharmacological interventions need to be tailored to the individual client, whether adult or child, and the client needs to be watched for any increase in agitation or suicidality.

In a study assessing 20 randomized controlled trials that examined the effectiveness of treatments of patients who have deliberately harmed themselves, treatments were placed in distinct categories (Guthrie et al., 2001; Hawton et al., 1998). These treatments were compared with standard care, which involved the usual range of treatment options available in routine care at the time of each trial. One category, containing four studies, looked at problem-solving therapy versus standard care. Each study reported reduced repetition of deliberate self-harm with patients in the experimental groups. Similarly, with DBT versus standard care, there was a significantly lower rate of repetition of self-harm during follow-up with patients who received DBT. Alternatively, the categories that involved intensive intervention plus outreach, or emergency card (that is, providing 24-hour telephone contact with staff), or inpatient behavior therapy versus standard care, showed no change with regard to deliberate self-harm. Categories that compared the same therapist with a different therapist and general hospital admission versus discharge were inconclusive as regards effectiveness. There were also no apparent benefits found with regard to long-term as compared with short-term therapies. In terms of pharmacological interventions, flupenthixol versus placebo showed a significant reduction in repetition of deliberate self-harm, whereas for antidepressants versus placebo, there was no apparent benefit to patients.

Given the period of extremely high risk in the year following discharge from inpatient treatment for mental disorder, a focus on discharge planning is crucial (NACYSP, 2000). Pilot projects creating services with an early intervention and outreach focus, along with strong links
with other agencies, suggest improvements in client thinking with regard to suicide and self-harm.

Brief Community-Based Interventions

Crisis Centers and Hotlines

The telephone help line dates back to the 1950s and 1960s in the United Kingdom and the United States when suicide prevention centers began to emerge through organizations such as the Samaritans, Befrienders International, and Lifeline (Goldney, 1991). These centers were developed as autonomous services that were intended to complement more traditional forms of health care (Daigle & Mishara, 1995). Burns and Patton (2000) have described suicide call centers as a type of “indicated intervention,” by which they mean services specifically targeted at individuals who exhibit symptoms of deliberate self-harm, drug, alcohol or substance abuse, or subsyndromal depression. Crisis centers and hotlines typically use a combination of trained volunteers and paid staff to provide telephone counseling to individuals in crisis. The centers may also be linked to mental health services and other associated social welfare agencies. Roberts (2000) aptly identifies and discusses the application of crisis intervention protocols and techniques to callers with suicidality risk and other self-destructive behavior patterns. The fundamental aims of the telephone crisis line are to detect at-risk individuals by identifying recent suicidal behavior or ideation, and conducting a rapid lethality assessment, then through active listening trying to stabilize the individual by suggesting positive coping methods and, where appropriate, directing callers to further counseling or emergency clinical intervention (Roberts, 2000). Given the popularity of telephone counseling centers and 24-hour crisis hotlines surprisingly little systematic research has been conducted on them, and opinion is divided about their effectiveness (Bagley, 1968; Barraclough, Jennings, & Moss, 1977; Lester, 1993, 1994; Medoff, 1984). Most of the outcome studies that have been conducted have relied on epidemiological data showing changes in suicidality following the establishment of a call center in a telephone region (e.g., Mishara & Daigle, 1992; Slem & Cotler, 1973; Stein & Lambert, 1984) or else on caller feedback regarding service quality (e.g., Shapiro, Ossip-Klein, Gerrity, & Stiggins, 1986). Results of such studies have so far been equivocal, both because of inconsistent findings and because of such studies’ obvious methodological shortcomings. Indeed, the dearth of supporting evidence has led some critics (e.g., Burns & Patton, 2000) to claim that the vast appeal of telephone centers comes more from the low cost of service provision than from knowledge of their effectiveness.

Method Restriction

One of the major reasons for the substantial gender difference in suicide rates is the preference by males for the more lethal methods of shooting, hanging, and asphyxiation by car exhaust. Females, by contrast, tend to favor drug overdose, frequently of prescription medicines. Nevertheless, the widespread replacement of highly toxic barbiturate medication with benzodiazepines in the 1960s (Steenkamp & Harrison, 2000) reduced male and female suicide rates and underscored the potential of method restriction as a prevention measure (see also Moscicki, 1995).

Birckmayer and Hemenway (2001) used regression analysis to examine the relationship between suicide rates and household firearm ownership for four age groups in nine U.S. census regions from 1979 to 1994, adjusting for regional divorce rates, education, unemployment, and urbanicity. Results showed that firearm owner-
ship levels are correlated with suicide rates among 15–24-year-olds and 65–84-year-olds, but not among 25–64-year-olds. The authors concluded that, presuming the relationship is causal, a 10% fall in regional firearm ownership levels would lead to a 3.0% decrease in suicide rates.

In a fascinating case study, Beautrais (2001) examined the impact of the removal of suicide safety barriers from a central Australian city bridge on suicide rates. Data for suicide deaths by jumping from the bridge in question were obtained for the years 1992 to 2000 from the regional City Police Inquest Office. Data for suicide deaths over the same period by jumping from other sites in the metropolitan area were obtained from the national health statistics database. Results showed that in the 4 years following the removal of the barriers (compared with the previous 4 years) the number of suicides increased from 3 to 15, and the rate of such deaths also increased. The majority of those who died by jumping from the bridge following the removal of the safety barriers were young male psychiatric patients, with psychotic illnesses. However, following the removal of the barriers, the pattern of suicides by jumping in the city changed significantly with more suicides from the bridge in question and fewer at other sites. As a result, the overall suicide rate in the area was unaffected.

This case study is therefore consistent with other evidence suggesting that method restriction works only in the short-term and that alternative means are soon found, such as happened in Great Britain when the introduction of natural gas replaced coal gas. Although suicide rates immediately declined following the introduction of natural gas, alternative methods were soon found and suicide rates returned to pre–natural gas levels within a decade (Smith & Rutter, 1995). While accepting the equivocal evidence in support of method restriction, Takahashi, Hirasawa, and Koyama (1998) contend that the highly lethal methods, such as guns, should be restricted legally as far as possible but that unless restriction is implemented extensively for an extended period, the effect of the legislation might be offset by other means. As for herbicides, pesticides, or prescription drugs, it makes common sense to promote the production of safer products and the prohibition of highly lethal ones.

**Indirect Case-Finding**

Educating potential gatekeepers, teachers, parents, clergy, youth workers, and peers, to identify the warning signs of an impending suicide may be advantageous (Metha et al., 1998; Shaffer et al., 2001; Zubrick & Silbrun, 1996). About 80% of people who ultimately commit suicide have communicated their intention to someone (Knott & Range, 1998), so training modules could be offered to counselors to prepare them for dealing with a person expressing suicidal intent. Preliminary studies in Sweden suggest that educating primary practitioners in a 2-day training course to identify and treat mood disorders resulted in a reduction in the number of suicides and suicide attempts among females and an increase in antidepressant prescriptions and hospitalizations (Shaffer et al., 2001). Another 2-day training workshop known as *Applied Suicide Intervention Skills Training* (ASIST) was completed by 120 chaplains and their assistants in the United States Army, with the intention of better identifying at-risk soldiers and getting them into treatment (Hasenhauer, 2001). By contrast, school-based education programs appear to be ineffective in identifying suicidal adolescents and may actually increase the risk of activating suicidal thoughts. Virtually all of the suicide prevention programs employ a stress model of suicide, as opposed to a mental illness model (Diekstra et al., 1995) and the emphasis in these programs is that everyone is vulnerable to suicide. The rationale behind this approach is to
destigmatize suicide and to encourage students who are feeling suicidal to identify themselves and seek help. However, these suicide prevention programs run the risk of misrepresenting the role of serious depressive disorder in suicides as well as normalizing the behavior and reducing potentially protective taboos. In the evaluative studies conducted on curriculum-based suicide prevention programs, results have so far been either ambivalent or negative, with some students responding by seeing suicide as a possible solution to what might be considered normal adolescent problems (Diekstra et al., 1995; Shaffer et al., 2001).

Physicians have a central role in early intervention and suicide prevention because of their frequent contact and unique relationship with their patients (NACYSP, 2000; Stapleton, 2001). Despite the complexities surrounding the exact relationship between depression and suicidal behaviors, it is believed that early identification and treatment of depressive disorders can play a vital role in a suicide prevention program (Martin et al., 1997). The WHO suggests that the organization of global, regional, and national multi-sectoral activities to increase awareness about suicidal behaviors and their effective prevention is vitally important (www.who.int/mental_health). Only then will adequate support and treatment of at-risk populations be developed, access to the means of suicide be reduced, and networks of survivors of suicide attempts be strengthened.

**Direct Case-Finding**

Direct case-finding has been suggested as a cost-effective way of identifying possible at-risk young people in a school setting and involves systematically screening 15–19-year-olds for previous suicide attempts, or recent, serious suicidal ideation, depression, or complications of substance or alcohol abuse (Shaffer et al., 2001). There is ample evidence that teenagers will truthfully reveal such information (Fritz, 2001) and young people identified in this way can be referred on for evaluation and treatment. Primary care physicians, school counselors, juvenile justice staff, and other professionals working with young people can employ the direct screening approach, either through interviews or self-report questionnaires (Fritz, 2001).

Thompson, Egert, Randell, and Pike (2001) conducted a study to evaluate the efficacy of two suicide risk preventive interventions, postintervention and a 9-month follow-up for potential high school dropouts. Of the 1,546 high risk youths identified as potential dropouts, 460 were identified as being at risk of suicide and were randomly assigned to participate in one of 3 groups: (a) Counsellors CARE (C-CARE) \( n = 150 \); (b) Coping and Support Training (CAST) \( n = 155 \); and (c) usual care control \( n = 155 \). C-CARE included a one-to-one, 2-hour assessment interview, followed by an additional 1 1/2 to 2 hours that included a counseling session and social “connections” intervention with parents and school personnel. CAST involved a 12-session (12 hours) small-group skills-training program combined with the C-CARE individual approach. Usual care (control group) included a brief (15 to 30 minutes) assessment interview and social “connections” intervention with parents and school personnel. Growth curve analyses showed significant rates of decline in attitude toward suicide and suicidal ideation associated with the experimental interventions. C-CARE and CAST, compared with usual care, were also effective for reducing suicidal behaviors and related emotional distress, and for enhancing protective factors.

Martin (1998) developed a 12-item Brief Adolescent Risk Taking Scale (BARTS), which is recommended as a brief screen for risk-taking in population studies of 12–18-year-olds. The BARTS covers family structure, personal life events in the previous 6 months, including parental bonding, suicidal thoughts and behavior, depression,
delinquency, drug and alcohol issues, and music preference. The BARTS appears to be sensitive to delinquent and self-harming behaviors, and to the gradation of seriousness within the spectrum of suicide. The Early Detection of Emotional Disorders Program is another comprehensive bio-psycho-social predictive scale based on risk identified for suicidal behavior (Martin et al., 1997), which is also aimed at adolescents.

**Media Communications**

Overall, the evidence to date suggests that suicide contagion is a real effect, albeit of a smaller effect size than many other psychiatric and psychosocial risk factors for suicide (Velting & Gould, 1997). Hassan (1995), for example, investigated the impact of media coverage on the incidence of suicide in Australia. Suicide stories appearing in two major metropolitan newspapers during 1981–1990 were examined for their position, size, and contents. Daily average male and female suicides were computed for the day of the high impact story and the following 2 days. The daily average male suicide rate increased significantly during the high impact period. Female suicide rates showed no such variance. Results showed that high impact stories may raise the suicide risk among vulnerable young men.

Stack’s (2000) recent review of the literature analyzed 293 findings from 42 studies on the possible impact of publicized suicide stories on suicide between 1974–1996. A logistic regression analysis found that characteristics of the stories were key predictors of finding a copycat effect. In particular, studies measuring the presence of either an entertainment or political celebrity suicide were 14.3 times more likely to find a copycat effect than studies that did not. Studies based on real stories as opposed to fictional stories were 4.03 times more apt to uncover an imitation effect. The medium of coverage was a significant predictor of copycat effects with televised stories being 82% less likely to affect suicide than newspaper-based stories. Not surprisingly, then, the suicide of rock star Kurt Cobain in 1994 raised concerns among suicidologists and the public generally about the potential for his death to spark copycat suicides. However, data obtained by Jobes et al. (1996) from the Seattle–King County area suggested that the expected effect did not occur, although there was a significant increase in suicide crisis calls following his death. Jobes et al. (1996) hypothesized that the lack of an apparent copycat effect in Seattle may have been due to various aspects of the media coverage, the method used in Cobain’s suicide, and the crisis center and community outreach interventions that occurred.

After the implementation of the subway system in Vienna in 1978, jumping in front of trains became an increasingly common means of committing suicide, with suicide rates showing a sharp increase as a result (Etzersdorfer & Sonneck, 1998). This and the fact that the mass media reported about these events in a very dramatic way, led to the formation of a study-group of the Austrian Association for Suicide Prevention, which developed media guidelines and launched a media campaign in mid-1987. After the Austrian Association for Suicide Prevention issued its media guidelines, suicides were rarely reported, and never in a sensational manner. The number of subway suicides and attempts dropped more than 80% from the first to the second half of 1987 and have remained at a comparatively low level ever since.

According to Martin (1998) there is firm evidence that reports about celebrities that are multimodal, repeated, explicit, front page, glorify the suicide, and describe the method lead to an increase in deaths from suicide, particularly in the region in which reports are published. What appears to be crucial is a collaborative approach between professionals and the media to promote a negative attitude toward suicide without in-
creasing stigma toward those with mental health problems.

Postvention

A high risk factor for suicide is family members or close friends of those who have completed suicide, so psycho-educational counseling in individual or group settings is often said to be beneficial (Shaffer et al., 2001), particularly if it begins soon after the tragedy (Leenars and Wenckstern, 1998). One such program was developed by Petretic, Pitman, and Jackson (1996) for university athletic departments after the suicide of college athletes. The model is run in groups and covers stages of establishing rapport, trust, and a working relationship with the affected teams and individuals; providing information regarding the nature and circumstances of the student-athlete’s suicide; addressing and dealing with feelings; assessing distress levels and risk of lethality of significantly affected individuals; developing an action plan; and maintaining ongoing consultation and follow-up after resolution of the crisis.

Callahan’s (1996) case study sounds a warning signal about the need to design postvention programs very carefully. Callahan initially carried out fairly standard postvention activities in a middle school after two youths from the same neighborhood committed suicide 3 months apart. Soon thereafter, a substantial increase in suicidal talk, threats, and attempts took place. Inadvertently, some of the postvention activities appeared to contribute to the romanticization and glorification of the deaths. Changes in postvention practices were made in order to defuse the atmosphere of “romantic tragedy,” which in turn led to a decrease in suicidal behavior.

Parenting Programs

Family counseling is an important approach to suicide prevention because systemic factors, such as family interaction patterns are known to play an important role in precipitating and preventing suicide. Family counseling appears to be equally applicable to families with children or a parent at risk for suicide (McLean & Taylor, 1994). Cognitive-behavioral family therapy has been shown to have merit when working with suicidal individuals (McLean & Taylor, 1994) and family counselors using cognitive-behavioral methods help families to develop better methods of interpersonal functioning and to correct dysfunctional thinking.

A somewhat different approach was taken in an Australian program called Parenting Adolescents: A Creative Experience (PACE). This program was trialed and evaluated in 18 sites across Australia among parents of at-risk 13-year-old children (Mitchell, 2000). The program sought to develop parenting skills, build parents’ self-esteem, increase parents’ confidence, and decrease parents’ depression. Compared with adolescents in a control sample, children whose parents were involved in the program displayed a trend towards decreased self-harm, decreased delinquency, decreased substance abuse and increased family attachment—all of these being risk factors for suicide.

Cultural Programs

For high-risk children from cultural minority groups, another prevention approach that has been trialed is the promotion of involvement and pride in their cultural identity. One such program was recently trialed among suicidal youth in some Aboriginal communities in eastern Australia (Capp, Deane, & Lambert, 2001). The program also incorporated a series of community gatekeeper training workshops, which aimed to increase the potential of key members of the community to identify and support young people at risk of suicide and to facilitate their access to professional helping services. It was suggested that this program could be transferred to
other ethnic communities, particularly those
that are tight knit and have fairly close geo-
graphical boundaries. Suicide awareness and
skills training have been demonstrated to be an
effective early intervention strategy.

A number of culturally-based suicide preven-
tion programs have also been undertaken among
American Indian and Alaska Native Community
ies where self-destructive behaviors, including
suicide, are a significant health and social con-
cern (Middlebrook, LeMaster, Beals, Novins, &
Manson, 2001). Systematic evaluation has not
yet been undertaken so the effectiveness of the
programs cannot be determined. Where rates of
suicide attempts and completions were recorded,
there were decreases after a preventive program
or intervention was delivered, which is possible
evidence of program effectiveness. Some of these
programs focus on the lack of cultural and spiri-
tual development, cultural confusion and accul-
turation, intervening with high-risk parents to
reduce the incidence of suicidal behavior among
their offspring, creating youth community cen-
ters, creating a primary preventive intervention
for suicide clustering, and developing alterna-
tives to incarceration for adolescent substance
abuse and status offenders.

Discussion

In summary, a number of brief educational, pre-
vention and intervention strategies have been
suggested by researchers and clinicians, some of
which are based largely on the experience and
practice wisdom of those who work with people
contemplating suicide. Existing suicide pro-
germs can be classified into one of two groups:
clinically based casework, conducted by trained
therapists; and broader, community-based pro-
germs, conducted by gatekeepers such as teach-
ers, medical practitioners, youth workers, and
others.

To date there have been very few randomized

controlled trials to assess the different interven-
tions that have been proposed in the literature
(Shaffer et al., 2001; Zubrick & Silbrun, 1996).
And many of the trials that have been con-
ducted have included too few participants to de-
tect clinically significant differences in rates of
repeated self-harm; others have been conducted
without control groups, or with inadequate evalua-
tive procedures (Arensman et al., 2001). Evi-
dence for the efficacy of such trials is de-
pendent predominantly on the opinions of au-
thorities, clinical experience, and descriptive
studies (Zubrick & Silbrun, 1996). In future tri-
als, information needs to be provided on meth-
ods of randomization and intervention, standard
measures of outcome need to be used, and there
needs to be a focus on homogeneous subgroups
of patients.

Most existing strategies also focus on children
(10–14 years of age), adolescents (15–19 years of
age), and young people (20–24 years of age), de-
spite the fact that the increase in suicides in the
last 30 years is particularly alarming among men
25–34 years of age (Cantor, Neulinger, & deLeo,
1999). Little is known as to whether suicide and
parasuicide are the same phenomena in adoles-
cence as in adulthood, and how the meanings
and risk factors for suicide vary from childhood
through to old age (Diekstra et al., 1995).

Notwithstanding these qualifications, most of
the techniques reviewed here at least provide
grounds for optimism that brief interventions
for suicide prevention can be successfully and
cost-effectively mounted both at the clinical
level with at-risk individuals and at the level of
community-wide initiatives.

References

Alvarez, A. (1971). The savage god: A study of sui-
Arensman, E., Townsend, E., Hawton, K., Bremer,
S., Feldman, E., Goldney, R., Gunnell, D., Hazell,


Velting, D. M, & Gould, M. S. (1997). Suicide conta-


