Chapter 38

Suicide and the Gifted Adolescent: Advice for Counselors

Lori Andersen and Tracy L. Cross

There is no event that brings greater sadness to a school than the death of a member of the school community. The death of a child by suicide is a great tragedy that leaves the entire community wondering why this young person chose to end his or her own life. Loved ones left behind may ask themselves why they did not see the warning signs or take sufficient action. In this chapter, suicidal behaviors, potential causes, and warning signs of suicide will be reviewed, with particular focus on how these may be different for gifted students than for non-gifted students. This chapter will answer the following questions: Are the gifted at higher risk for suicide? What can counselors do to reduce the risk of suicidal behavior in gifted students?

Suicide in Adolescents

Suicide is relatively rare among children and adolescents. It is possible that a counselor could have an entire career without ever experiencing the loss of a student at his or her school by suicide. However, suicide ranks as the third leading cause of death among adolescents (Xu, Kochanek, Murphy, & Tejada-Vera, 2010). In 2007, 4,140 people aged 15–24 years and 184 people aged 5–14 years committed suicide (Xu et al., 2010). For each of these young people who complete suicide, it is estimated that there are as many as 200 more unsuccessful

attempts (McIntosh, 2010). A recent national survey of 15,010 college undergraduates revealed that more than half of them had thought about suicide and 8% had attempted suicide at least once in their lives (Drum, Brownson, Denmark, & Smith, 2009). The high prevalence of suicidal thoughts in young people identifies suicide as a salient issue to be addressed in schools.

Gifted Adolescent Suicide

As death certificates do not contain information about giftedness and definitions of giftedness vary between locales, differentiating suicide rates between the gifted and nongifted is impossible. The current state of knowledge indicates that the unique characteristics of gifted students do not translate to increased suicidal behavior among this group. Baker (1995) found no significant differences in rates of depression or suicidal thinking between academically gifted and nongifted high school students. Recent studies of suicidality in gifted populations (Cassady & Cross, 2006; Cross, Cassady, & Miller, 2006; Cross & Cross, 2011) provide insight into how gifted and nongifted students compare in their thinking about suicide. To correctly apply suicide risk factor considerations to the gifted population requires sensitivity to the common personality profiles of gifted adolescents that affect the individual concepts of self (Cassady & Cross, 2006). In-depth investigations into completed suicides, called psychological autopsies, have provided detailed views into the lives of gifted adolescents who completed suicide (Bell, Stanley, Mallon, & Manthorpe, 2010; Cross, Cook, & Dixon, 1996; Cross, Gust-Brey, & Ball, 2002; Hyatt, 2010). This chapter will present important findings that can help counselors understand the nature of the suicidal behavior of gifted students and implement effective suicide prevention programs.

Terms and Definitions

Suicidality refers to all suicide-related behaviors and thoughts, including four categories of behaviors: suicidal ideation, suicidal gesture, suicidal attempt, and suicide completion. *Suicidal ideation* is the act of thinking about killing oneself. People who think about killing themselves are called *ideators*. A *suicidal gesture* is a suicidal action that has been determined to not be a serious attempt to end one's life. Those who take such actions are called *gesturors.* Any action taken with the intent to kill oneself that results in failure, regardless of severity, are referred to as *suicidal attempts,* and those who engage in them are *attemptors*. The behaviors that result in death of the attemptor are called *suicide completions*. Those who die by suicide completion are called *completers* by suicidologists (O'Carroll, Berman, Maris, & Moscicki, 1996).

Table 38.1
Rates of Suicide in the United States per 100,000 Population

Year	Ages			
	5 to 14	15 to 24	75–84	All ages
1999	0.6	10.1	18.1	10.5
2000	0.7	10.2	17.6	10.4
2001	0.7	9.9	17.4	10.8
2002	0.6	9.9	17.7	11.0
2003	0.6	9.7	16.4	10.8
2004	0.7	10.3	16.3	11.0
2005	0.7	10.0	16.9	11.0
2006	0.5	9.9	15.9	11.1
2007	0.5	9.7	15.6	11.5

Note. From Xu et al. (2010).

National Data on Suicidal Behaviors

To make comparisons of suicidal behavior between age groups or over time, suicidologists use prevalence rates rather than the actual number of completions. The large differences between the number of members in the various age groups mean that comparisons of the numbers of completions can mask differences in rate among populations. For example, the total number of suicide completions in 2007 was 4,140 for ages 15 to 24, which is higher than the 2,119 completions for ages 75 to 84 (Xu et al., 2010). However, the comparative prevalence rates for the two groups are 9.7 and 16.3 respectively. The prevalence rate is a better indicator of the likelihood of a member of a specific group to complete suicide; therefore, prevalence rate has more meaning when making comparisons. The prevalence rates for suicide completions or selected age groups are shown in Table 38.1. The past 10 years have seen little change in the suicide rate for the 15 to 24 age group with the prevalence rate hovering around 10 per 100,000. The data reported in Table 38.1 is likely to be lower than the true prevalence rate for suicide. The accuracy of this information depends on the reports of cause of death; these numbers are likely underestimates of suicide completions due to misreporting of cause of death for reasons such as social stigma or insurance rules (Xu et al., 2010). Data for attempts, gestures, and ideations are not known for the entire population and the wide range of behaviors within these categories further complicates attempts to study them. For example, a suicide ideation can range from a fleeting thought of killing oneself to persistent suicidal thoughts leading to the making of an actual plan to kill oneself. The more severe and pervasive the ideation, the greater the likelihood of a later suicide attempt (Bridge, Goldstein, & Brent, 2006).

Table 38.2
Suicide-Related Behaviors of Students in Grades 9–12 in the U.S. in 2009

Behavior (during the last 12 months before the survey)	Prevalence Rate (%)
Seriously considered attempting suicide	13.8
Made a plan about how they would attempt suicide	10.9
Attempted suicide one or more times	6.3
Suicide attempt resulting in an injury, poisoning, or an overdose that had to be treated by a doctor or nurse.	1.9

Note. From U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health (2010).

Suicide in the General Adolescent Population

The national Youth Risk Behavior Survey (YRBS) is conducted every 2 years and monitors the suicide-related behaviors of U.S. students in grades 9–12. The survey asks questions about suicidal ideation to represent this category of behavior (Table 38.2). These data indicate that a significant number of high school students are ideators, gesturers, and attemptors. Although specific data on gifted students are not available, previous research has found that the rate of suicidal ideation among gifted adolescents is similar to that among their nongifted peers (Baker, 1995; Cross et al., 2006). Without other evidence, one must assume that the rates of suicidal behaviors for gifted students are similar to those of all students.

It is important to note that suicidal ideation often occurs in some form before a gesture, an attempt, or a completion takes place. Pinto, Whisman, and McCoy (1997) found that 85% of attemptors expressed ideation before the attempt. There are many times more people who think about suicide than who gesture, attempt, or complete. There are people who do not go farther than thinking about suicide, but there are also those who ideate and then have a failed attempt. Some will stop after failed attempts. A smaller number ideate and then complete. It is rare for someone to experience all four categories of behavior. However, someone who has exhibited suicidal behavior in the past is at 50 to 100 times greater risk for future suicidal behaviors compared to the general population; 0.5%–1.0% of attemptors later complete suicide (Bridge et al., 2006).

Risk Factors for Suicidal Behaviors in Young People

Available research supports the belief that the suicidal behaviors of gifted children are not much different than those of the general population of children (Baker, 1995; Cross et al., 2006). Thus, important findings about the suicidal

behavior for the general population of children and adolescents will be reported first before addressing the population of gifted students specifically.

Risk factors for adolescent suicide. Gould, Greenberg, Velting, and Shaffer (2003) conducted a review of a decade of adolescent suicide research and describe the following as significant risk factors:

- psychiatric disorders such as depression and anxiety,
- substance abuse,
- cognitive and personality factors (hopelessness, coping skills, neuroticism),
- aggressive-impulsive behavior,
- sexual orientation (homosexual, bisexual),
- friend or family member of someone with suicidal behavior,
- parental psychopathology (depression, substance abuse),
- stressful life circumstances (interpersonal loss, legal/disciplinary),
- glamorization of suicide through media coverage, and
- access to lethal methods (firearms).

Two theories of suicide. One theory illustrates the commonalities, complexity, and multicausal nature of suicide. The Suicide Trajectory Model (Stillion & McDowell, 1996) conceptualizes the complexity of contributing factors to suicidal ideation. This model generalizes risk factors to four major categories: biological, psychological, cognitive, and environmental. Particular risk factors within each category are illustrated in Table 38.3. The interaction of multiple risk factors must be considered when assessing suicide risk (Stillion & McDowell, 1996).

A second theory of suicide addresses the motivating factors and how to remedy suicidal behavior. The father of suicidology, Edwin Shneidman (1993), identified the key element in suicide risk as psychological pain, or *psychache*, that drives the individual to decide that suicide is the best solution to end this pain. The sources of psychache are complex, encompass many affective states, and are fueled by frustrated psychological needs. The threshold for psychache is different for every person. Within the individual, some unmet needs can be tolerated and others cannot; those that cannot may potentially lead to suicide. The remedy for suicidal behavior is to address and satisfy the unmet psychological needs; this remedy is specific to the individual. A small reduction in the unmet needs can be enough to save a life (Shneidman, 1993).

Theories as frameworks. Examination of risk factors in adolescence using the two theories can help in understanding the reasons why young people may contemplate suicide. Adolescence is a period of major psychological change associated with a child's preoccupations about fitting in with peers (need for acceptance) while simultaneously trying to develop an individual identity. Any dif-

Table 38.3
Suicide Trajectory Model Categories and Associated Risk Factors

Category	Risk Factors
Biological	Gender (male) Race (Native American, White) Genetic bases (parental psychopathy) Sexual orientation (homosexual, bisexual) Serotonin dysfunction
Psychological	Low self-esteem Depressed mood Feelings of hopelessness/helplessness Aggressive-impulsive tendencies Poor coping strategies Existential questions
Cognitive	Poor social problem solving Inflexible thinking Negative self-talk Rigidity of thought
Environmental	Familial dysfunction (impaired parent-child relationships) Social isolation Stressful life circumstances (interpersonal loss) Presence of lethal methods Exposure to suicide completers (friends/family)

ficulty in meeting basic psychological needs can create psychache. For example, homosexual and bisexual youth are often stigmatized and not accepted by peers; these youth have a 200%–600% higher chance of nonlethal suicidal behavior (Gould et al., 2003). This increase in risk can be explained by the unmet psychological need creating a potentially unbearable psychache. Bullying has been recognized as a contributing factor to suicidal behavior; often the victims and perpetrators of bullying are socially isolated (Hazler & Denham, 2002). Social isolation can create an unmet need of love and belonging. For some children, the home environment is not supportive and family conflicts, divorce, and its associated parental loyalty issues can lead to additional unmet psychological needs. Poor coping mechanisms in young people may prevent them from seeing alternative solutions to problems and can potentially lead to the decision that suicide is the only way to end psychache. Ninety percent of youths who complete suicide have been diagnosed with a psychiatric disorder (Wintersteen, Diamond, & Fein, 2007); any dysfunction associated with psychiatric disorders impacts the threshold for psychache. Risk factors have been gathered through research with the goal of understanding the motivations for suicidal behavior and can explain why an individual may have a lower threshold for psychological pain or identify contributing factors to psychache. According to Shneidman (1993), it all comes down

Table 38.4
Consensus Warning Signs of Suicide

A person at risk for suicidal behavior most often will exhibit warning signs such as:		
Letter	**Represents**	**Description**
I	Ideation	▪ Expressed or communicated ideation ▪ Threatening to hurt or kill him- or herself, or talking of wanting to hurt or kill him- or herself ▪ Looking for ways to kill him- or herself by seeking access to firearms, available pills, or other means ▪ Talking or writing about death, dying, or suicide when these actions are out of the ordinary
S	Substance Abuse	Increased substance (e.g., alcohol or drug use)
P	Purposelessness	No reasons for living; no sense of purpose in life
A	Anxiety	Anxiety, agitation; unable to sleep or sleeping all the time
T	Trapped	Feeling trapped—like there's no way out
H	Hopelessness	Hopelessness
W	Withdrawal	Withdrawing from friends, family, and society
A	Anger	Rage, uncontrolled anger, seeking revenge
R	Recklessness	Acting reckless or engaging in risky activities, seemingly without thinking
M	Mood Changes	Dramatic mood changes

Note. From McIntosh (2010).

to individual psychological pain. The key for educators and counselors is to try to address unmet psychological needs and prevent suicide. To assist counselors, a list of warning signs of suicide has been compiled through consensus among experts in the field.

Warning signs. Rudd et al. (2006) defined a warning sign as "the earliest detectable sign that indicates heightened risk for suicide in the near-term (i.e., within minutes, hours, or days)" (p. 258). A warning sign describes a dynamic feature directly related to suicide rather than a static risk factor that may have a causal relationship or predictive power. An Internet search will locate many lists of warning signs of suicidality. The American Association of Suicidology convened a working group to develop a consensus-based list and has developed a mnemonic to remember the warning signs of suicide: "Is path warm?" (Juhnke, Granello, & Lebrón-Striker, 2007). Table 38.4 illustrates the warning signs represented by this mnemonic.

Effect of giftedness on risk. It is unknown if the prevalence rate of suicidal behaviors is different for gifted students compared to their nongifted peers. Existing research supports the notion that the rates of suicidal behaviors are not

significantly different between gifted students and nongifted students (Cross et al., 2006). Are the psychological needs of gifted adolescents different? If so, then knowing those unique needs can guide the planning of appropriate interventions.

Personality types in gifted adolescents. Gaining an understanding of the differences in personality profiles of gifted adolescents can create sensitivity to self-concept that is needed to conduct an appropriate suicide risk factor analysis (Cassady & Cross, 2006). The Myers-Briggs Type Indicator (MBTI; Myers, 1962) has been the most popular personality type instrument used with student populations. The MBTI describes a person's preferred way of interacting with the world using four scales: Introversion-Extraversion (I-E), Sensing-Intuitive (S-N), Feeling-Thinking (F-T), and Perceiving-Judging (P-J) to categorize personality type. Alignment of the learning environment with individual type preferences can be considered a psychological need. Recent research has shown that the typical personality profile of a gifted adolescent differs from the norms of the overall population (Hawkins, 1998). Studies have shown that the perceiving (P) and intuitive (N) personality types occur with higher frequency in gifted adolescents than the general population of adolescents (Cross et al., 2006; Cross, Speirs Neumeister, & Cassady, 2007; Sak, 2004) and that these personality types may be associated with greater susceptibility to psychological distress, depression, and suicidal behavior (Cross et al., 2006). Gifted adolescents have been found to be evenly split on the E-I dimension of the MBTI compared to a definite preference for E over I reflected in the overall population (MacDaid, Kainz, & McCaulley, 1986). Although I is not characteristic of the majority of gifted adolescents, compared to the general population, the gifted population shows a higher frequency for I, and this personality type is described by a reluctance to participate in social activities and a more internal orientation (Cross et al., 2007). Therefore, MBTI profiles can be helpful to counselors in identifying the psychological types of individual students who may have the N, P, and I dimension preference(s) and are at higher risk for suicidal behavior. Skills training interventions should be designed to teach gifted adolescents methods of coping with distress. The mismatch between the instructional offerings or teaching styles in the school and the learning preferences of this group can contribute to psychache (Cross et al., 2007). Improving the alignment between the preferences of the student and instruction could reduce distress for this group and should be considered in instructional design and services for gifted students.

Psychological characteristics of gifted adolescents. A recent study at a residential academy for students gifted in math, science, and humanities indicated that there may not be much difference in the psychological characteristics of the gifted and the nongifted. Personality type describes an individual's preferred ways of interacting with the world, whereas psychological characteristics are a set of

Table 38.5
Characteristics of Gifted Young People Associated With Suicide Risk

Characteristic	Supporting Research
Perfectionism	See Greenspon, this volume; Blatt, 1995
Isolation (related to extreme introversion)	Hazler and Denham, 2002
Severe self-criticism	See Mendaglio, this volume
Severe identity problems	See Frazier, this volume
Dyssynchrony in development	See Silverman, this volume
Dabrowski's overexcitabilities (psychomotor, sensual, intellectual, imaginational, and emotional)	See Probst & Piechowski, this volume

particular behaviors and emotional difficulties including depression, anxiety, psychopathy, paranoia, hypomania, and social introversion. Cross, Adams, Dixon, and Holland (2004) used the Minnesota Multiphasic Personality Inventory Adolescent Version (MMPI-A; Butcher et al., 1992) to compare the psychological characteristics of this sample of gifted students to population norms and found no significant differences between the MMPI-A profiles of the two groups on any of the MMPI-A subscales. Individual students within the sample who had elevated levels of psychological dysfunction showed decreases in those levels during the 2-year time span of the study, indicating that placement in the academy may have alleviated psychological pain (Cross et al., 2004). This points to appropriate educational environments as a factor in psychological health for gifted students.

Other characteristics of gifted adolescents. Many researchers (Cross et al., 2002; Dixon & Scheckel, 1996) have summarized characteristics associated with gifted young people that may affect suicide risk (see Table 38.5). It is possible that warning signs of suicidal behavior, such as an intense emotional response to personal loss, could be mistaken for a characteristic of being gifted. However, it is important to treat all signs of psychological pain or potential suicide as serious and for peers and adults to intervene to assess the level of risk. Cross et al. (1996) emphasized that counselors need to address signals of distress, particularly when the signal might be construed as a sign of giftedness. Signals such as atypical divergent thinking, extreme emotionality, obsession with dark or negative themes, excessive introspection, and sensitivity are reasons for assessment of the individual for risk of suicidal behavior.

The findings of psychological autopsies of eight gifted adolescents (Bell et al., 2010; Cross et al., 2002; Cross et al., 1996; Hyatt, 2010) provide evidence to support the notion that risk factors and warning signs that apply to the general adolescent population also apply to the gifted adolescent population. In these investigations, researchers found common precursors to suicide completion such

as victimization by bullying, discussion of suicide methods with a peer group, keeping secret thoughts in journals, struggling to find meaning in one's life, experiencing rejection in school, and indications of a lack of trust in adults. At the same time, suicide completers displayed many of the characteristics in Table 38.5 such as overexcitability in the form of intense emotions, conflict, pain, and confusion and were relatively isolated (Cross et al., 1996). Additional risk factors apply to gifted adolescents because of the different manner in which they respond to situations that is likely due to differences in personality type. Suicide completers often have many contributing factors to their own personal psychache. The presence of a peer group that supports the idea of suicide as an honorable solution can lead to an adolescent perseverating on the idea of suicide as a way to end a psychologically painful situation. Therefore, students need to be taught how to deal with intense feelings and stressors by rationally evaluating all of the possible solutions to painful situations.

Interventions

Knowledge of risk factors and warning signs can assist counselors in the identification of youth in crisis who need immediate attention. This is an important part of the counselor's function in a school.

Responding to a Young Person in Crisis

The presence of *any* of the warning signs in Table 38.4 warrants an appropriate clinical intervention to ensure the child's safety (Juhnke et al., 2007). For example, if a student reports suicide ideation, possible interventions could range from close daily monitoring of the student to hospitalization, depending on the severity and duration of the ideation. Just making a statement that life is not worth living places a young person at risk, but does not require hospitalization. However, outpatient mental health services can help prevent escalation of symptoms and progression to more severe categories of suicidal behavior (Wintersteen et al., 2007).

Assess risk. Individuals who exhibit signs of distress should be actively questioned (Reis & Cornell, 2008). The Question, Persuade, Refer program provides training to counselors to guide their interactions with potentially suicidal youth (see http://qprinstitute.com). Wintersteen et al. (2007) provided a decision matrix for assessing suicide risk and selecting referral options developed for use with adolescents. The evaluation has four simple questions and guidance on how to assess suicide risk based on responses. First, ask the student two questions directly:

(1) “Have you felt like life is not worth living?” and (2) “Have you wanted to kill yourself?” A positive response to the first question indicates moderate suicide risk and necessitates a referral to a social worker or psychologist (Wintersteen et al., 2007). Suicidal individuals can be reluctant to seek or accept help, therefore it is important to persuade them to accept a referral and to either accompany the student or secure an agreement from the student to get professional help (Reis & Cornell, 2008). If a positive answer is made to the second question, this indicates high suicide risk. For high-risk individuals, follow up with two additional questions: (3) “Have you ever tried to kill yourself?” and (4) “Have you made plans to kill yourself?” A positive response to question 3 elevates the suicide risk to imminent. High and imminent risk cases should be referred to a crisis team and may warrant hospitalization.

Create a safety plan. Negotiation of a safety plan is critical to assessment and treatment of suicidality (Bridge et al., 2006). This plan should address the securing of lethal methods, precipitating events to the crisis, emotional regulation, an agreement to inform a responsible adult if suicidal impulses occur, and a method for coping with suicidal urges (Drye, Goulding, & Goulding, 1973). A refusal to sign a safety plan is a clear sign of a need for immediate help (McConnell Lewis, 2007). However, there is a paucity of empirical evidence to support safety plan effectiveness (Bridge et al., 2006); the safety plan may be of more use as an assessment of suicidality rather than as a contract for no harm (McConnell Lewis, 2007). A safety plan should not be the only intervention used.

Measures to Reduce Risk for All Students

Responding to the individual in crisis should not be the only approach to suicide prevention used in a school. A proactive approach can make a difference in the lives of many young people in comparison to waiting for the moment of crisis for intervention. A practical, multipronged plan addresses responses to the individual in crisis, suicide awareness, and programmed skills training to have the maximum impact. At the proactive end of the prevention spectrum, wide-scale screening can reliably identify those students who are thinking about suicide and facilitate early intervention to possibly prevent further or more severe suicidal behavior.

Suicide awareness training. Suicide awareness programs prepare teenagers to identify peers who are at risk and take appropriate action. The logic behind such programs is twofold. First, suicidal ideators are most likely to confide in a peer instead of a teacher or parent (Reis & Cornell, 2008). Second, for half of ideators, ideations lasted less than one day (Drum et al., 2009). The short duration of ideations make it more likely that a friend would notice the behavior. Students

should be taught to be empathetic toward peers and to persuade peers to seek help from a responsible adult because "a mad friend is better than a dead friend" (Adams, 1996, p. 416). All students should learn about suicide warning signs and how to help a peer who expresses suicidal thoughts.

Skills training. A primary component of a school suicide prevention program is training for all students that focus on individual wellness and development of social competency (Adams, 1996). Skills training programs should emphasize the development of coping, problem-solving, and cognitive skills to make up for deficiencies that youth may have in these areas and to reduce suicide risk factors such as depression (see Chapter 37 by Neihart, this volume), substance abuse, and hopelessness. This component of suicide prevention can be tailored to suit the psychological type, particular risk factors, and warning signs associated with gifted students. Based on the needs of the school population, guidance departments should develop goals and objectives for suicide prevention programs (Adams, 1996).

Screening. Schoolwide screening is another approach to suicide prevention. Several instruments are available for screening students, such as the Suicide Ideation Questionnaire (SIQ; Reynolds, 1987). Although screening instruments are highly effective in identifying ideators, a sizable number of false positive results will be generated in a large-scale screen. It is well established that direct screening of students for suicidality has no adverse effects on the likelihood of future suicidal behavior (Gould et al., 2005). One potential issue is the availability of means to address the needs of students who are positively identified. Wide-scale screening should not be undertaken without the means to provide intervention for all such identified students. These students should be interviewed and asked directly about their thoughts and intentions regarding suicide. Screening students for possible affective disorders (anxiety or obsessive-compulsive) and conduct disorders would help counselors identify students who are at greater risk for suicidal behaviors (Adams, 1996).

Intervention Strategies Targeted to Gifted Adolescents' Needs

Generally, prevention recommendations for the general population guide suicide prevention measures for the gifted student population. Knowledge about differences in psychological type and the specific risk factors for gifted adolescents (see Table 38.5) can direct the planning of specialized skills training interventions to address these needs. Cross et al. (1996) recommended that a proactive stance be taken with gifted adolescents including teaching gifted adolescents about their emotional experiences and needs, establishing and maintaining communication between adults and adolescents, challenging ideas of suicide as an honorable solu-

tion, balancing positive and negative themes in curricular and resource materials used with students, and assessment for emotional, psychological, or relationship difficulties. Hyatt (2010) made four specific recommendations for action: reduce bullying, establish relationships between adolescents and adults, educate adults on the characteristics and social-emotional needs of gifted adolescents, and teach adolescents that self-worth comes from their uniqueness, not perfection. Strategic interventions designed with these goals in mind will benefit all students, not just gifted students.

Conclusion

This chapter has discussed risk factors associated with suicide for both the general adolescent population and for gifted adolescents using two theories—Stillion and McDowell's (1996) suicide trajectory model and Shneidman's (1993) psychache—to facilitate understanding of why a young person would consider or attempt suicide. Evaluating risk and providing an appropriate intervention is an important job of a counselor. Suicide risk and protective factors can be attributed to the individual, family, peers, school, or community (see Table 38.6). Awareness of the potential impact of social groups on suicidality can help counselors to identify the predisposing, contributing, and precipitating factors likely to increase risk and intervene appropriately. Prevention programs or skills training should strive to develop protective factors in the individual and social support groups. Research indicates that the risk factors of suicide for the general adolescent population are valid for the gifted population. Everyone's awareness of potential risk factors and warning signs is a necessary part of suicide prevention. Knowing students' characteristics and establishing relationships with students will help counselors to monitor potential suicidality. Suicide warning signs should be familiar to everyone in the school community, including families of students. The presence of any warning signs warrants immediate intervention. The importance of relationship building between adolescents and the responsible adults in their lives cannot be overemphasized as a preventive measure. Above all, if there is any doubt as to the state of distress in a student, act on suspicions—talk to the student and assess the situation.

For gifted students, measures of personality type, such as the MBTI, can be useful tools to learn more about gifted young people and their psychological needs. Preferences for I, N, and P types should be considered in planning suicide prevention and academic curricula. Poor alignment of instruction and curricula with the preferences of the NP personality profiles typical of gifted learners can be a potential contributor to psychache; better alignment can reduce distress. Imag-

Table 38.6
Suicide Risk and Protective Factors

Key Content	Predisposing Factors	Contributing Factors	Precipitating Factors	Protective Factors
Individual	▪ Previous attempt ▪ Depression/psychiatric disorder ▪ Prolonged or unresolved grief	▪ Rigid cognitive style ▪ Poor coping skills ▪ Substance abuse ▪ Sexual orientation issues ▪ Impulsivity ▪ Hypersensitivity	▪ Personal failure ▪ Humiliation ▪ Trauma ▪ Developmental crisis	▪ Easy temperament ▪ Creative problem-solving ▪ Personal autonomy ▪ Self-mastery experience ▪ Optimistic outlook ▪ Sense of humor
Family	▪ Suicidal behavior or completed suicide ▪ Violence or abuse ▪ Psychiatric disorders ▪ Early childhood loss or separation	▪ Substance abuse ▪ Instability ▪ Ongoing conflict	▪ Loss of significant family member ▪ Death—by suicide	▪ Warmth & belonging in family relationships ▪ Adults model healthy adjustments ▪ High & realistic expectations
Peers	▪ Social isolation & alienation	▪ Negative attitudes of seeking adult help ▪ Modeling maladaptive behaviors	▪ Teasing/cruelty ▪ Interpersonal loss ▪ Rejection ▪ Death—by suicide	▪ Social competence ▪ Healthy peer modeling ▪ Acceptance & support
School	▪ Long-standing history of negative school experiences ▪ Lack of meaningful connection	▪ Disruption during transitional periods ▪ Staff reluctant or uncertain how to help	▪ Failure ▪ Expulsion ▪ Disciplinary crisis	▪ Adults who believe in them ▪ Parent involvement ▪ Participation encouraged
Community	▪ ”Legacy” of suicide ▪ Marginalization ▪ Political disempowerment	▪ Media portrayal of suicide ▪ Access to firearms or lethal methods ▪ Gatekeepers reluctant or uncertain how to help ▪ Inaccessible resources ▪ Economic deprivation	▪ Celebrity death by suicide ▪ Conflict with law or incarceration	▪ Opportunities to participate ▪ Hope for the future ▪ Self determination & solidarity ▪ Available resources

Note. From White (2010). Reprinted with permission.

ine yourself trapped in an environment where your way of thinking about the world is discouraged or not valued at all. This type of continual discouragement can lead to psychological pain. The threshold of psychological pain for each student is unknown; steps must be taken to reduce it. However, empirical evidence suggests that the psychological profile of a gifted adolescent is not significantly different than that of the nongifted adolescent (Cross et al., 2004).

Evidence from psychological autopsies of adolescents suggests that students are more likely to confide in a peer than an adult (Cross et al., 1996; Hyatt, 2010) and surveys of students have revealed that typical periods of suicide ideations are not prolonged (Drum et al., 2009). Thus, programs that minimize dependence on identifying the moment of greatest suicide risk are needed. Suicide awareness, screenings, and skills training programs can meet this need. Skills training programs benefit all students by strategically working to reduce suicide risk factors, helping to increase positive coping mechanisms and decreasing depression. It is also important to realize the protective factors of the connections among adolescents, their peers, responsible adults, and the community in minimizing the risk of suicidal behaviors. Every member of the community must be vigilant in looking for signs of distress and responding with empathy. Distressed students must be questioned about suicidality, persuaded to get help if needed and referred to appropriate professionals. When in doubt, do something!

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