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| Let’s Talk About Suicide |
| Facilitating safe, effective discussions at UW-Madison |
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| This guide is intended to provide information and resources to any member of the University of Wisconsin-Madison community who will be leading discussions about suicide or mental health issues. UHS encourages dialogue about mental health on our campus and wants to help support these conversations so they may happen in safe, effective ways. |

# Emotional Intelligence: Why discuss sensitive topics in an academic setting?

“All learning has an emotional base.” – Plato

Sensitive topics, such as suicide, can evoke a wide range of emotions. These themes also bring up the questions, “What is the value of discussing such sensitive topics in an academic setting?” and, “How can these discussions happen in emotionally safe and meaningful ways?”

Emotional intelligence refers to one’s ability to perceive, control, and evaluate emotions. Building this intelligence is a crucial step in individual development. Our feelings and emotions ultimately guide our thinking and actions, whether we are aware of it or not. And, to get back to the question at hand, a key step in developing emotional intelligence involves using emotions to promote thinking and cognitive activity. At UW-Madison, we pride ourselves on providing a liberal arts education to our students. The Wisconsin Idea promotes educational experiences both in and out of the classroom. We hope that students leave our university with an understanding of how their coursework is relevant to their lives and communities. Emotional intelligence is an often undervalued aspect of a college education that prepares people to navigate relationships and contribute to the world around them.

Having an open dialogue in an academic setting communicates to students that these issues are important to both emotional and intellectual development. Talking about mental health issues helps reduce stigma and makes it clear that UW-Madison respects the very real and diverse experiences students bring to the classroom.

If conversations about trauma or suicide are happening in academic settings, students need to know that instructors value their feelings and wellbeing. Instructors can do this by providing a warning before reading sensitive material. Without a warning, students may feel bombarded with difficult memories or emotions, especially if they have personally had traumatic experiences. Their sole focus will be dealing with their own reaction to the material, which may interfere with their ability to engage academically. Instructors can also help create a safe space in the classroom by establishing ground rules for discussion and stressing the importance of using respectful language and listening practices.

Finally, when discussing sensitive topics, instructors should know what resources exist for any student who might feel negatively impacted or overwhelmed by the material. University Health Services is available 24-hours a day if students need support processing their emotions or have other mental health concerns.

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# *Let’s Talk About Suicide: Facilitating safe, effective discussions at UW-Madison*

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I. Background on Suicide & Mental Health among College Students

### Suicide Prevalence

* Suicide is the second leading cause of death among college students nationwide. (Suicide Prevention Resource Center, 2011).
* Available data suggests that suicide occurs at a rate between 6.5 and 7.5 per 100,000 among college students per year, approximately half the rate for nonstudent college-aged adults ([Silverman et al., 1997](http://www.sprc.org/collegesanduniversities/research/big-ten-student-suicide-study-10-year-study-suicides-midwestern-uni); [Drum et al., 2009](http://www.sprc.org/collegesanduniversities/research/new-data-nature-suicidal-crises-college-students-shifting-paradigm)).

### Suicidal Thoughts

* At UW-Madison, approximately 8% of students reported seriously considering suicide at least once in the prior 12 months [(National College Health Assessment, 2015)](http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Fall2011.pdf).

### Mental Health

* At UW-Madison, 31% of students say they "felt so depressed that it was difficult to function" in the prior 12 months [(National College Health Assessment, 2015)](http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Fall2011.pdf).
* Even though most campuses provide low- or no-cost mental health services to their students or can refer students to off-campus services, student survey data shows that many students who need help are not asking for it directly. Most students who report being depressed (i.e., screening positive for depression, self-reporting depression diagnoses or symptoms) are not in treatment ([American College Health Association, 2008](http://www.sprc.org/collegesanduniversities/research/national-college-health-assessment-reference-group-executive-summar); [Eisenberg et al., 2007b](http://www.sprc.org/collegesanduniversities/research/help-seeking-and-access-mental-health-care-university-student-popul)).

### Survivors of Suicide

* A survivor of suicide is a family member or friend of a person who died by suicide.
* Survivors of suicide represent “the largest mental health casualties related to suicide” (Edwin Shneidman, American Association of Suicidology Founding President).
* There are currently over 38,000 suicides annually in the USA. It is estimated that for every suicide there are at least 6 survivors. Some suicidologists believe this to be a very conservative estimate.
* Based on this estimate, approximately 5.5 million Americans became survivors of suicide in the last 25 years.
* At UW-Madison, about 20% of students identify as survivors of suicide (HMS, 2016).

II. Creating a Safe Space for Discussion about Suicide

### Consider the format and logistics

* Ensure the conversation occurs in a place where everyone feels comfortable and safe.
* Allow enough time for the presentation or discussion so that questions can be answered and support can provided if necessary.
* If possible, have at least two facilitators or support staff in the room in case a participant needs to step out. There should be someone available to check in with them.

### Give advance notice and be clear about expectations

* Prepare in advance. Give notice that the issue will be raised and what might be covered.
* Always share mental health resources along with your discussion.
* Set ground rules and expectations before the discussion starts and ensure support options are available for those who may become upset during or after the discussion.
* Sometimes group discussions will not be the best place for participants to talk about personal experiences. This will depend on the focus of the discussion and whether the participants know each other. Discuss revealing personal details up front.
  + Example: “Since this is going to be a general discussion about suicide/mental health and we want everyone to participate, this may not be the best place to share distressing or personal experiences. I am happy to talk afterwards to let you know who you can talk to if you want to discuss a specific experience.”
* Consider and research cultural barriers that may hinder the discussion of suicide in some communities and prepare for them beforehand.

### Use an experienced facilitator who is appropriate for the audience

* Ensure that whoever is facilitating the discussion has credibility with the target group, is comfortable talking about suicide, and can manage challenging comments or emotional responses.
* Ideally, the person leading the discussion should have experience or training in suicide prevention so they can talk in ways that are accurate and safe.
* For group sessions it would be ideal to have two facilitators – one to lead the discussion and one to manage responses, although this may not always be possible.
* Consider inviting local mental health professionals, such as school or university counsellors, community health staff, or relevant cultural leaders to be part of the discussion.

### Handle the discussion sensitively

* When leading a discussion, it is important not to place any moral or value judgments on the act of suicide. It is also important not to push people to talk or participate when they would prefer not to.
* Facilitators should be knowledgeable enough to provide context and facts that address any myths or misconceptions about suicide that are raised.
* It is important that facilitators know how to challenge views in a supportive and respectful way, so people feel comfortable to share their opinions and participate in the discussion.
* During the conversation, use an optimistic tone, highlighting people’s strengths and emphasizing that suicide is preventable.
* Facilitators should respectfully challenge and clarify any inappropriate comments to ensure the safety of all participants. Monitor participants’ responses and have systems in place to support anyone who becomes distressed.

III. How to Talk About Suicide Appropriately

### Focus on increasing knowledge and/or skills

* Focus on how people can contribute to suicide prevention and the knowledge they need rather than merely talking about the extent of the problem.
* Messages that can be built on and reinforced over time are more effective than one-off sessions. Think about providing follow-up sessions or multiple opportunities to get further information.

### Avoid simplistic explanations of why suicide occurs

* Avoid simplistic explanations that suggest suicide might be the result of a single factor or event.
* Placing discussions about suicide in the context of risk factors and other mental health issues can assist in breaking down myths about suicide.
* Ensure that your discussions alert rather than alarm the audience.
* Check the accuracy of your information and use only reputable sources. Communicating unsubstantiated, sensational or inaccurate information is unhelpful and potentially dangerous.

### Choose language carefully

* Certain ways of talking about suicide can alienate members of the community or inadvertently contribute to suicide being presented as a glamorous, ideal or common option for dealing with problems. Certain words can negatively impact people bereaved by suicide or people vulnerable to suicidal thinking.
* Avoid judgmental phrases. Do not place any moral judgments on the act of suicide.
* Sometimes language can be misinterpreted especially across different cultural groups. Be mindful of the cultural aspects of language.
* Avoid discussing the methods or locations of suicide deaths in detail. Talking in specific detail about the methods of suicide or locations where suicides occur can create images that are upsetting for people and can increase risk in people vulnerable to suicide.

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| **Do say** | **Don’t say** | **Why?** |
| ‘non-fatal’ or  ‘made an attempt on his/her life’ | ‘unsuccessful suicide’ | So as to not normalize or glamorize a suicide attempt |
| ‘took their own life’’ or  ‘ended their own life’ | ‘successful suicide’ or ‘completed suicide’ | So as to not present suicide as a desired outcome |
| ‘died by suicide’ or  ‘deaths by suicide’ | ‘committed’ or ‘commit suicide’ | So as to avoid the association between suicide and ‘crime’ or ‘sin’ |
| ‘concerning rates of suicide’ or ‘number of deaths’ | ‘suicide epidemic’ | To avoid sensationalism and inaccuracy |

IV. Common Terminology

* **Best Practice** - Activity keeping with the best available evidence regarding what is effective
* **Contagion or “Copy-Cat” Suicide -** A term used to describe how exposure to suicide or suicidal behavior of one or more persons influences others to attempt or die by suicide. Some forms of non-fictional media coverage of suicide are associated with a statistically significant increase of suicide among others exposed to the media coverage.
* **Evidence-based** – Programs that have undergone evaluation and are proven to be effective
* **Gatekeepers (suicide gatekeepers)** – Individuals trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate; gatekeepers can be non-professionals who work with at-risk populations including administrators, coaches, home health aides, and others
  + *At UW-Madison we do not use this term to refer to training and education we provide. “Gatekeeper” can have an exclusionary tone and we are committed to providing inclusive services and programming.*
* **Intervention** – A strategy or approach intended to prevent an outcome or alter the course of an existing condition
* **Means** – The instrument or method whereby a self-destructive act is carried out
* **Means restriction** – Activities designed to reduce access or availability to means and methods of deliberate self-harm (i.e., gun locks, med drops, safety structures on high buildings/bridges)
* **Mental disorder/Mental illness** – A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual’s cognitive, emotional or social abilities
  + *At UW-Madison we often instead use the language “mental health issues/concerns” to avoid pathologizing or inaccurately/unnecessarily diagnosing.*
* **Non-suicidal self-injury (NSSI):** The various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness. Can also be referred to as *self-harm*.
* **Postvention** – A strategy or approach implemented after a crisis or traumatic event has occurred.
* **Prevention** – A strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.
* **Protective factors** – Factors that make it less likely for individuals to develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment. Some protective factors may include:
  + Individual Characteristics and Behaviors – emotional well-being, positive beliefs and hopes for future, internal locus of control, problem solving skills, self-esteem, physical health
  + Social Support – connectedness to family and friends, social involvement, positive mentors, ongoing support and support to call on in times of crisis
  + School and Community – supportive and inclusive peer group, connectedness to community, availability and accessibility of support services, access to effective health care, access to wellness resources, restricted access to lethal means
* **Risk factors** – Those factors that make it more likely for individuals to develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment. Some risk factors may include:
  + Behavioral Health Issues/Disorders – depressive disorders, substance abuse, previous attempts, self-injury
  + Individual Characteristics – hopelessness, loneliness, isolation, lack of belonging, impulsivity, poor coping skills or lack of resiliency, perception of being a burden
  + Adverse/Stressful Life Circumstances – relationship troubles, school or work problems, financial problems, chronic illness or disability, insomnia
  + School and Community – limited access to effective health care, stigma associated with seeking help, exposure to negative environments, access to lethal means
* **Stigma** – An object, idea, or label associated with disgrace or reproach.
* **Substance abuse** – A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.
* **Suicidal behavior** – A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.
* **Suicidal ideation** – Self-reported thoughts of engaging in suicide-related behavior.
* **Suicidality** – A term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.
* **Suicide** – Death where there is evidence that a self-inflicted act led to the person’s death.
* **Suicide attempt (or suicidal act)** - A potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.
* **Suicide attempt survivors** – Individuals who have survived a prior suicide attempt.
* **Suicide clusters -** A suicide cluster may be defined as a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community.
* **Survivors of suicide**– Family members, friends, significant others, acquaintances, co-workers and others who have experienced the loss of a loved one due to suicide.

V. Mental Health & Suicide Prevention Resources

University Health Services is the student health center at UW-Madison. In addition to medical care, they are dedicated to promoting prevention, wellness, and mental health. They offer UW-Madison students a variety of free, confidential mental health services, and they are committed to providing services to a diverse population in a culturally sensitive manner.

Some of the mental health services they offer students include:

* Individual, group, and couple/partner counseling

**UHS Counseling and   
Consultation Services**

333 East Campus Mall, 7th floor

M|T|R|F: 8:30am- 5:00pm

Wed: 9am to 5pm

Phone: 608-265-5600

[www.uhs.wisc.edu](http://www.uhs.wisc.edu)

**24-Hour Crisis Services:**

608-265-5600 (option 9)

* Let's Talk: drop-in consultations around campus
* Psychiatric services, including medication management
* Alcohol and drug assessment
* Disordered eating assessment and treatment
* 24-hour crisis line for students or those concerned about a student
* Care managers to assist students with finding community mental health providers, navigating health insurance or sliding-scale fees, and providing follow-up care
* Consultative services for third parties who are concerned about a student
* Post-hospitalization consultation and appointments
* Wellness services: stress management, meditation, nutrition, and sleep

For more information about the mental health services offered at UHS, visit <http://www.uhs.wisc.edu/services/counseling/>.

If you are interested in learning more about suicide prevention on campus, visit the UHS suicide prevention page at <http://www.uhs.wisc.edu/umatter/>, or email [suicideprevention@uhs.wisc.edu](mailto:suicideprevention@uhs.wisc.edu).