Students' Involvement in Bullying and Risk of Suicide: Implications for Olweus Bullying Prevention Trainers and Coordinating Committees

1. What does the OBPP have to say about bullying and suicide?

Background:

According to the Centers for Disease Control (CDC, 2009), suicide is the third leading cause of death among 15- to 24-year olds. Fifteen percent of high school students seriously considered suicide in the previous 12 months, and 7% reported making at least one suicide attempt in the previous year. According to the CDC (n.d.), "a combination of individual, relational, community, and societal factors contribute to the risk of suicide," including a family history of suicide or child maltreatment, a history of mental disorders (especially depression) or alcohol and substance abuse, feelings of hopelessness, impulsive or aggressive tendencies, isolation, loss, physical illness, local epidemics of suicide, and easy access to lethal methods.

There is a growing body of research examining the association between involvement in bullying and suicide among children and youth. Most studies are correlation and show that children who are involved in bullying (as victims of bullying, perpetrators of bullying, or both) are more likely than those who are not to have depressive symptoms, high levels of suicidal thoughts, and attempted suicide (e.g., Annenberg Public Policy Center, 2010; Arseneault & Shakoor, 2010; Eisenberg, Newmark-Sztainer, & Story, 2003; Hinduja & Patchin, 2010; Kim, Leventhal, Koh, & Boyce, 2009; Klomek, Marrocco, Kleinman, Schoenfeld, & Gould, 2007, 2008; Pranjic & Bajraktarevic, 2010; Rigby & Slee, 1999; Roland, 2002; van der Wal, 2005). Children who bully and who also are bullied by peers (often referred to as "bully-victims") appear to be at the greatest risk for suicidal thoughts and behavior (see review by Kim et al., 2009). There are a number of important limits to these studies. First, several researchers note that children's experience with bullying explained only a very small amount of the variation in suidality (e.g., Hiduja & Patchin, 2010). Second, correlation studies do not imply causation. Although involvement in bullying is related to suicidality, one cannot conclude from these studies that experience with bullying causes suicidality.

Very few studies have used longitudinal methodologies (i.e., measure participants over time), and those that do (e.g., Kim et al.'s study of 7th and 8th graders in Korea [Kim et al.., 2009] or Klomek et al.'s studies of youth in Finland [Klomek, Sourander, Kumpulainen, Piha, Tamminen, Moilanen, Almqvist, & Gould, 2008; Klomek, Sourander, Niemela, Kumpulainen, Piha, Tamminen, Almqvist, & Gould, 2009] have sampled very specific populations and have

produced somewhat different findings depending on the sub-populations studied.

Conclusions from the research:

Suicide is one of the leading causes of death among young people in the U.S. Although children who are involved in bullying are at increased risk of suicidal thoughts and behavior, there are numerous individual, relational, community, and societal factors that contribute to youths' risk of suicide. The OBPP is a bullying prevention and intervention program that is designed to reduce bullying behavior, but it is not a suicide prevention program.

2. What are the implications for training and consulting with schools?
In other words, does OBPP have any expectations for trainers related to this issue?

Since many parents, educators, and members of the media may continue to connect bullying behavior and bullying prevention policies and practices in the schools directly to cases of student suicide. It is expected that OBPP trainers should be proactive in helping to clarify that bullying prevention is not synonymous with suicide prevention and that the OBPP is not a suicide prevention program.

1. OBPP trainers, in the pre-training consultation phase with the school leaders and as well as during the BPPC training, should communicate clearly that the OBPP is not a suicide prevention program. They should explain that bullying behaviors are related to increased depression in those who are being bullied, and that children who have been bullied do have more suicidal ideation than children who are not bullied and are more likely to have attempted suicide. However, suicide is a complex issue that typically involves far more than victimization from bullying. School personnel who actively work to prevent bullying, who are watchful for possible bullying, and who take quick actions to stop victimization are taking logical steps to help prevent suicide. However, these actions do not constitute comprehensive suicide prevention. In short, trainers need to give a clear message that "The OBPP is a bullying prevention and intervention program that is designed to reduce and address bullying behavior, but it is NOT a suicide prevention program."

2. Trainers should ask the school's administration and the BPCC members about what is in place in their schools to address suicide prevention specifically. Suicide issues are generally addressed by the school's Student Assistance Program and Student Services personnel. Trainers should find

out who has been given the responsibility to address suicide education, prevention and intervention in each of their schools. If no one is specifically responsible for suicide prevention issues, this finding should be communicated clearly to the school's top administrator immediately, making it clear that OBPP is NOT a suicide prevention program and that they may wish to take proactive steps to provide suicide prevention/ support for educators and parents.

3. If a suicide prevention representative and/or crisis response expert for the school is identified, it may be wise to include this person in the BPCC membership. Alternatively, at minimum, BPCC members need to know WHO to contact should they be concerned about a student. The school's Bullying Prevention Coordinating Committee, the Student Assistance Program chairperson, and administrators should be clear as to how to communicate with each other about specific concerns regarding suicide prevention/intervention.

4. Suicide prevention requires a comprehensive effort to identify mental health resources for students within the school and the larger community, training for educators and parents about suicide, training about the behavioral indicators that a student may be considering suicide, how to intervene effectively, how to communicate concerns to those needing to know, and how to get immediate help. Research-based suicide prevention/intervention programs should be explored and implemented.

5. Trainers who are certified in the Olweus Bullying Prevention Program can be looked to as "in-house consultants" on bullying prevention/intervention issues but should NOT be considered to be an expert or consultant on suicide issues, unless they have specific professional training/credentials to do so. OBPP trainers should feel comfortable and encouraged to say "Suicide prevention is NOT my area of expertise. I don't know the answer to your question, but I can help you find the person who can answer it."

6. We ask that trainers refrain from using the term "bullycide." This term, which is frequently used in the popular press, implies a simplistic causal relationship between bullying and suicide that is not supported by research. As stated earlier, suicide is a highly complex, multi-faceted issue and there are often many factors involved. Just as it would be inappropriate to refer to "depressioncide", divorcecide" or "financialcide", it is inappropriate to use the term "bullycide". Bullying may be a trigger for a suicide attempt by a student who is struggling, but it is problematic when we specifically imply that bullying or cyber bullying causes youth suicide.

7. In planning the formal kick-off event or class meetings, educators should be cautioned against using role play scenarios or videos of bullying behaviors that depict the site or method of a completed suicide. The impact of these presentations may be harmful to students who are seriously considering suicide.

   That is not to say that adults should not talk with students about suicide. In fact, it is a best practice to talk with students about suicide prevention. It is a myth that talking about suicide will put the idea in students' heads; not only are they already exposed to these concepts by peers and the media, there is no evidence of increased suicidal activity as a result of evidence-based suicide prevention programming.

8. If a suicide should occur, it is the responsibility of a district administrator or a designee to speak with the media, not the OBPP Trainer, the school's Bullying Prevention Coordinating Committee or BPCC Coordinator.

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