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Understanding why children and adolescents attempt suicide

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Abstract

Until recently, childhood suicidal behavior has been a relatively neglected area of systematic research and clinical concern (Wells & Stuart, 1980). There were several contributing issues. First, completed suicide among children was considered to be rare. Second, it was believed that, due to a lack of physical prowess, youngsters could not affect a fatal self-injury. Third, because children under ten may not realize that death is final, it was thought that, by definition, youngsters could not be considered suicidal. Consequently, vital statistics do not catalog self-killing as a cause of death in children under ten.

UNDERSTANDING WHY CHILDREN AND ADOLESCENTS ATTEMPT SUICIDE

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Until recently, childhood suicidal behavior has been a relatively neglected area of systematic research and clinical concern (Wells & Stuart, 1980). There were several contributing issues. First, completed suicide among children was considered to be rare. Second, it was believed that, due to a lack of physical prowess, youngsters could not affect a fatal self-injury. Third, because children under ten may not realize that death is final, it was thought that, by definition, youngsters could not be considered suicidal. Consequently, vital statistics do not catalog self-killing as a cause of death in children under ten.

The frequency of documented suicides has increased by about 400% in the last 20 years (Wellman, 1984). Suicide has become the third leading cause of death of America's youth (Greuling & DeBlassie, 1980). The significance of this trend is that professionals should place greater priority than ever before on identifying, understanding, and treating suicidal adolescents.

Suicide attempts and completions have been difficult to assess accurately (McGuire & Ely, 1984). This literature review revealed that many completions have not been reported because of the stigma and taboo attached to self-killing. This unfortunate stigma was

attached to surviving family members who were thought to be neglectful and cruel. The result of not reporting suicide has been to prevent families in need of help from getting help at a critical time. This pattern has suggested a need to review how professionals interpret the factors which contribute to the increased frequency of childhood and adolescent self-destruction.

Statement of the Problem

To date, professional literature has focused primarily on adolescents. However, the growing awareness that suicidal ideation can begin in childhood has suggested a need to study the literature on both age groups here. This review should be analyzed for recurring themes, common areas of agreement and disagreement, and any categories or components which might seem significant to professionals.

The following are specific questions to be answered:

1. What factors contribute to childhood suicide?
2. What stresses influence adolescents to become suicidal?

Importance of the Problem

The significance of the study was twofold. First, the suicide of a child or young person was a profoundly tragic and final event for surviving family and friends. The youngster had not grasped the opportunity to live a full life and suffered intensely. As a result, family members and friends had been devastated and were in danger of suicide themselves.

Second, because the frequency of self-killing has increased so dramatically, professionals should make greater effort to identify, understand, and prevent it. This literature review was intended to help this effort.

Review of Related Literature

This review dealt with suicide in two groups: children and adolescents. The first part of the review; on childhood suicide, dealt with the first research question: "What factors contribute to childhood suicide attempts?" The second part of the review; on adolescent youth, responded to the second research question: "What stresses influence adolescents to become suicidal?" The review concluded with a summary that synthesized the literature discussed.

Childhood Suicide

Pfeffer (1982) contended that many features observed in the dynamics of families of suicidal children were also found in families of non-suicidal offspring. He argued that the families of suicidal children were similar in the degree and quality of conflicts. However, these families demonstrated more intense and rigid perceptions, fantasies, wishes, fears, and member interactions.

Pfeffer (1982) concluded that there were five distinct features in these suicidal families. First, the family was organized to inhibit change. Second, there was a lack of defined generational boundaries. Third, there were severe spousal conflicts. Fourth, there was projection of inappropriate parental feelings onto the child. And fifth, there was often a symbiotic parent-child interaction.

In a family where change was inhibited, any personal striving was perceived as a threat to the family's integrity. For example, a family whose members had always entered public service might view a member who wanted to go into business as disloyal. Thus, the member might have felt inhibited.

According to Pfeffer (1982), the lack of defined generational boundaries came about when parents had not resolved conflicts of their own and were unable to adequately carry out parental role functions. As a result, the child had this added stress of caring for the parents.

Because the parents had not resolved conflicts of their own, there were frequent and severe spouse conflicts. Many of these difficulties stemmed from misperceptions between the spouses. Intense dependency often existed and one parent was frequently overtly depressed and suicidal.

As a result of the parents not resolving their own conflicts, parental feelings were frequently projected on the child. For example, the child might have been the repository of hostile, dependent, and ambivalent feelings from the parents which actually stemmed from the parents' own childhoods.

The last feature of suicidal families discussed was related to the second factor. There was often a symbiotic parent-child interaction. For example, Pfeffer (1982) wrote that a mother might want to be best friends with her daughter to fill a void left by her own emotionally-distant mother. Consequently, psychological autonomy would not be maintained and the child would

be left confused and paralyzed by parental prohibitions.

A team: Orbach, Gross, & Glaubman (1981) developed a tentative framework based on case analyses of suicidal children. As a consequence of these case studies, they presented six predictive factors of self-destruction in children. The six features were: presence of a suicidal parent, presence of a major family crisis, the child having the feeling of impingements and demands, a lack of satisfying relationships with adults, the perception of death as both frightening and attractive, and the presence of healthy aspects of personality.

The presence of a suicidal parent constituted an unfortunate burden on the child. If the parent and child had a closely symbiotic relationship, these suicidal wishes could unknowingly be transferred onto the child. For example, a daughter who wished to identify with her mother could internalize these self-destructive feelings as part of her own makeup.

Second, there often was a major crisis in the family. A consequence of this crisis was that the suicidal child usually was forced to take part in handling the crisis at the expense of his or her own unmet needs.

Third, the child had the feeling of impingements and demands. Tasks required of the child were often beyond their control or capabilities; hence the stress

might feel overwhelming. A refusal to comply with the parents' demands might be followed by withdrawal of love; punishment; or inducement of strong guilt feelings.

A lack of satisfying relationships with adults constituted the fourth feature. As a result, these children experienced a lack of warmth and attention plus frustration of important needs. For example, while in school a child might have demanded the exclusive attention of a teacher and may have shown extreme jealousy when other children got it. Such behavior could be viewed as an attempt to establish a secure relationship with a parent-figure as a compensation for unmet needs.

Fifth, these children perceived death as both attractive and frightening. These complex perceptions were reported to reflect the unique problems of the child's unhappy life. For example, if problems seemed unresolvable, self-destruction could be viewed as an option because all the problems would be gone.

The last feature was the idea that healthy aspects of the child's personality sometimes masked inner turmoil and depression. For example, a distressed child might still have tried to form interpersonal relationships, to express creativity, and to have showed sensitivity to others. Parents or teachers who saw these

positive behaviors would then view the child as normal when in reality the child was having serious problems.

Further research regarding child suicide revealed a number of other significant factors. Matter and Matter (1984) cited continuing and escalating experience with loss, and life stress such as academic pressures as important indicators. Loss may have included such events as divorce of parents or death of a grandparent. They also suggested that attempted suicide might be a desparate effort to gain some control over a crisis.

A study in McIntire and Angle (1980), in an exploration of children's view of death, found that the concept of the permanence of death did not often appear until about age 11. Before that, realism concerning organic decomposition was tolerated more for pets than for self. Death was viewed as a dreamlike, reversable state.

In a study of suicide notes (Wells & Stuart, 1980) a disciplinary crisis was a precipitating circumstance in 36% of the cases. The study involved 188 cases; 158 boys and 30 girls, whose deaths were listed by coroners as suicide because of suicide notes in 1977. Other frequently-occuring precipitants were fights with peers, a dispute with parents, and getting dropped from a

school team. In addition, social isolation appeared to be common with completers as nearly 40% were not at school on the previous day. A limitation of this study was that half of childhood suicides had not been accompanied by a note.

The studies of childhood self-killing described here suggested that common variables were usually identifiable; even if the precipitating crisis was unique. These commonly-occuring variables were: some type of loss, inadequate relationships with adults, a symbiotic relationship with a parent, depression, social isolation, school problems, and a history of disturbed family relations.

Adolescent Suicide

Greuling and DeBlassie (1980) emphasized five commonalities of adolescent self-killing. They are the quality of feeling that flowed between parents and young people; increased use of drugs and alcohol; the alienation of youth; increased stress among the young, and the population increase in this age group.

In regard to the quality of feeling, parents were often seen as intensely ambivalent by young people. The authors suggested that some self-destructive behavior may be a reflection of the unconcious conflicts of

the parents. For example, in some families stress was affecting all members but the particular adolescent, by being the scapegoat, received the most. This excess burden of stress and conflict was a precipitant to becoming suicidal.

Drug and alcohol abuse has been greater among the young now than in the past. The researchers did not believe that this was always a cause of suicide. They contended that a more appropriate explanation was that the same factors that led to increased abuse, such as poor peer relationships, could lead to thoughts of suicide.

Greuling and DeBlassie (1980) stated that the alienation of youth has been a nebulous,hard to define concept. They theorized that a prime cause of alienation has been deterioration of the American family. Factors such as the continued high rate of divorce and increased mobility lessened the positive influence of the family upon youth, thus many adolescents have become more peer-oriented than family-oriented.

Their last two commonalities; increased stress and a population increase in the age group were connected. Stresses for adolescents: achievement pressures, competition for good jobs, and a blurring of sex roles have intensified because of increased

numbers of young people. The increase was pinpointed as a ripple effect of the post World War II baby boom.

In another study Wellman (1984) described a five-stage model derived from interviewing attempters. First, the adolescents had a long-standing history of problems stemming from early childhood. Then, instead of diminishing or resolving, the problems escalated at the onset of puberty. Accordingly, they became less able to cope with stresses and exhibited more social isolation. In the following stage they were involved in a series of events that reduced the remaining social relationships and caused a precipitating event. Then, in the final and most critical stage, these attempters went through a self-justification of suicide. Like Greuling and DeBlassie's findings, Wellman (1984) highlighted family history and unresolved stress such as abnormal sibling rivalry.

Emery (1983) targeted depression as having been dominant in perhaps 80% of suicidal young people. He described four syndromes. One was acute depression which he described as short-lived and reversable. Chronic depression was another syndrome that usually occurred when experiencing a loss in the family. The third syndrome became apparent when behavioral equivalents of depression were exhibited as, for example,

when a shy youth suddenly exhibited risk-taking behavior. The last syndrome was characterized by masked depression. Young people suffering this tended to complain and be irritating.

Ray and Johnson (1983) cited causes consistent with Emery's findings. They cited depression, loss of parent, and alienation from family as the three major causes of adolescent suicide attempts. Other contributory factors sometimes were: a blurring of sex roles, the magical thinking that death is not final, and the increased mobility of young people. It should be noted that, with the exception of increased mobility, these factors have been previously cited as factors in childhood self-destruction.

A study in Peck, Farberow, and Litman (1985), in a study of completion cases, described similar causes as those presented by Ray and Johnson (1983). These components were loss of parent from either death or divorce and alienation. Academic pressure and population increase were also cited. Finally, another stress was also identified: rejection in romantic love.

Lastly, McAnarney (1979) studied stresses of youth from a completely different perspective; the influence of societal unrest. Changes in the American family, roles of women, minority status, formal

religion, mobility, achievement priorities, and expressions of aggression were the social forces emphasized. Suicide was defined as aggression and violence turned inward. Television violence was highlighted as a component that aggravated violent behavior.

Summary Analysis and Synthesis of Research

Ten components recurred as significant stresses for both age groups. Six of these were: alienation from parents and other authority figures; some type of loss; a rigid family structure; a symbiotic parent-child relationship; parental marital conflict, and a history of disturbed family relationships. These six components involved parents. It appeared that the most profound influence on the behavior and emotions of children and adolescents was the parents.

The stresses characteristic of childhood suicide were: an unrealistic, immature concept of death, and a strong need for adult support and approval. The belief that death is not permanent may have led some children to consider suicide as a coping mechanism to gain control over their lives.

There were five key areas of stress characteristic of adolescence. The five were: the onset of puberty; increased mobility; rejection in love; a history of problems, and an increase in population.

Implications for Practice

How should adolescents be approached compared to children? Professionals will need to be alert to assess, and address several of the characteristic stresses of their client's age group. Each relevant area of concern will need to be discussed so that the youth can receive empathy, support, insight, modeling, and acceptance. The young person can then be helped to develop more appropriate coping mechanisms than, for example, using drugs and alcohol. Lastly, the professional should be cognizant of the influence of peer relationships in the adolescent's world. Being accepted by peers is very important to the young person; feeling rejected can be traumatic.

Children, on the other hand, will be more likely to have problems concerning significant others which distress them. In addition, they need to be helped to understand that death, indeed, is permanent. This can be done by utilizing the child's own experiences concerning death, discussing his or her own conclusions, then helping the child to understand the permanence of death.

The implication for professionals is that relationships hold the key to saving lives. The suicidal child or young person believes that he or she is cut

off from the affection, nurturance, and support of others (Greuling & DeBlassie, 1980). Professionals need to help the troubled individual sort out emotions, improve self-esteem, and re-establish and improve the quality of their relationships. Utilizing key individuals such as family members is essential.

Because of today's crisis, it is necessary for adults to be aware of issues related to suicide. Through counseling, new behaviors can be learned so that suicidal threats, acts, or other non-adaptive behaviors can be eliminated. Families can be taught better communication and child-rearing skills so that children can develop in more stable environments. The greatest deterrant is the adult who is tuned in to children and willing to listen (McGuire & Ely, 1984).

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