1986

A literature review of adolescent suicide prevention in American secondary schools

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Abstract

Adolescent suicide is a problem experienced more and more frequently in American families. Death statistics remove any doubt that there is a desperate need for a program for prevention of adolescent suicide. Mercy, Talsma, Smith, and Conn (1984) found that the suicide rate in the United States among 15- to 24-year-olds more than tripled from 1950 to 1980, moving from the fifth leading cause of death for this age group in 1960 to become the third leading cause of death in 1980. Between 1970 and 1980, 49,496 American youth aged from 15 to 24 killed themselves, increasing the suicide rate 40 percent in only ten years.

A LITERATURE REVIEW OF ADOLESCENT SUICIDE PREVENTION IN AMERICAN SECONDARY SCHOOLS

A Research Paper

Presented to

The Department of Educational Administration

and Counseling

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts in Education

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by

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May 1986

This Research Paper by: Myrna Sandvik

Entitled: A LITERATURE REVIEW OF ADOLESCENT SUICIDE PREVENTION IN AMERICAN SECONDARY SCHOOLS

has been approved as meeting the research paper requirements for the Degree of Master of Arts in Education.

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April 17, 1986
Date Approved

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April 18, 1986
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4/18/86
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Adolescent suicide is a problem experienced more and more frequently in American families. Death statistics remove any doubt that there is a desperate need for a program for prevention of adolescent suicide. Mercy, Tolsma, Smith, and Conn (1984) found that the suicide rate in the United States among 15- to 24-year-olds more than tripled from 1950 to 1980, moving from the fifth leading cause of death for this age group in 1960 to become the third leading cause of death in 1980. Between 1970 and 1980, 49,496 American youth aged from 15 to 24 killed themselves, increasing the suicide rate 40 percent in only ten years.

Other statistics which point out the seriousness of the problem are those of Wellman (1984) and of Berman (1985). Wellman reported that since 1977, within the 15- to 19-year-old group, suicide has surpassed homicide to become the second leading cause of death. Accidents remain the leading cause. Berman found that one of every five suicides in the United States was committed by a 15- to 24-year-old male. Between 1960 and 1980, this group's suicide rate increased 136 percent, and more than doubled (from 5.2 per 100,000 in 1960, to 12.3 per 100,000 in 1980).

These statistics seem even more grim when unsuccessful attempts are considered. McKenry, Tishler, and Christman (1980) estimated that for every successfully completed suicide

within the 15- to 24-year-old group, there were as many as 50-150 unsuccessful attempts.

A further sobering thought voiced by McKenry et al. (1980) was that because of religious taboos, the limitations of insurance policies, and the social stigma of suicide, an estimated 50 percent of adolescent suicidal behavior may have been disguised or not reported at all. The above statistics indicate that suicide may have become the greatest single cause of teen-age death in the United States.

In a preliminary review of professional literature, authorities tended to basically agree regarding the most common causal factors and general identifying symptoms which are significant in dealing with adolescent suicide. However, there has been little movement towards prevention, especially at the national and state levels. Before 1980 there were virtually no pragmatic suggestions for prevention of suicide in adolescents.

The purpose of this study will be to review the professional literature in the area of prevention of adolescent suicide. Emphasis will be placed on preventative measures which have been used in the past in secondary schools and also upon programs which are currently being considered for use in secondary schools. Because it is expected that preventative measures will be based upon perceived causes of suicide,

literature pertaining to causes and symptoms of adolescent suicide will also be reviewed briefly.

The secondary school system appears to be the most logical setting for emphasis on adolescent suicide prevention and education because it provides a natural atmosphere for both a preventative education program, and individual on-going relationships within which adolescent behavior changes might be readily observed.

Causes of Adolescent Suicide

The review of literature revealed the individuality of adolescents' reasons for committing suicide, as well as causes that appeared to be common to the majority of cases. An important finding by Tishler, McKenry, and Morgan (1981), Rosenkrantz (1978), and Spero (1981) was that adolescent suicide was usually characterized by a dual causality in which one of the elements was of a long-standing depressive nature and the second element was a temporary stress to which the youths reacted by impulsively killing themselves.

Rosenkrantz (1978) and Berman (1983) believed that both a precipitating stressful situation and long-term psychodynamic factors were present in most adolescent suicide cases, but that the extent to which each influenced a particular young person's decision to commit suicide was an individual matter. Rosenkrantz found the core factors of adolescent suicidal

behavior to be the felt loss of love and intimacy, the adolescent's interpretation of the loss as it affected his/her self-worth, and perhaps a death bond with a parental figure.

Berman (1985) and Rosenkrantz (1978), as well as Ishii (1981) believed that the impulsive nature of the suicidal act was characteristic of adolescent suicides when compared to suicides of adults. In his research, Ishii found that adolescent suicides in English, American, and Japanese cultures were comparable and that the "ambivalent period" between making the decision to commit suicide and actually doing it, averaged one week or less for university students, with an even shorter time frame for younger students.

Based on 3,741 coroners' reports of definite suicides between the ages of 10 and 24 from 1925 to 1979, Cosand, Bourque, and Kraus (1982) found that young people who committed suicide were largely those who had psychological problems which prevented them from adapting normally to pressures they encountered in society. Cosand et al., plus several other authors (Farberow, 1983; Grob, Klein, & Eison, 1983; Ray & Johnson, 1983), pointed out that the loss of a parent during adolescence was perhaps the most important causal factor in adolescent suicide. Ray and Johnson emphasized that, in addition to loss of a role model, very damaging feelings of

rejection caused by divorce, or death or desertion of a parent were experienced as feelings of guilt and uselessness.

Belonging to a dysfunctional family was viewed as a second contributing factor in suicidal behavior in teenagers. Topol and Reznikoff (1982) found that suicidal adolescents tended to come from less well-adjusted families than non-suicidal teens or controls, and to perceive their families as unavailable, rejecting, or overprotective.

The family as a precipitator of adolescent suicide was further implicated in a study conducted by Tishler, McKenry, and Morgan (1981), who found that 52 percent of their group of 108 adolescent suicide attempters gave parental problems as the reason for their suicide attempt. Other reasons given were: problems with the opposite sex, 30 percent; school problems, 30 percent; problems with siblings, 16 percent; and problems with peers, 15 percent. Significantly, almost 50 percent of the adolescents reported divorced parents, and almost 60 percent rated their parents' marriage as poor. Tishler et al., concluded that a dysfunctional family background resulted in feelings of rejection and of not being loved.

The above data indicate that adolescents who are at high risk for suicide because of their perceived family situations may experience an unusual amount of stress and may impulsively

commit a suicidal act. The data also indicate that there are definite symptoms that generally indicate an adolescent who is at high risk to commit suicide.

Symptoms of Adolescent Suicidals

The American Association of Suicidology (cited in Morgan, 1981) listed five significant warning signals which can be used to identify specific individuals who are at high risk of committing suicide. They were: (a) suicide threats or similar statements; (b) an attempted suicide; (c) prolonged depression; (d) dramatic changes of behavior or personality; and (e) making final arrangements.

Depression was considered either the precipitating factor or a symptomatic behavior in adolescent suicide by Wellman (1984), Berman (1985), Forrest (1983), Ray and Johnson (1983), Miller (1975) and Grueling and DeBlassie (1980). Although the emotion most frequently reported by suicidal adolescents was depression, Miller and Greuling and DeBlassie found that sometimes it was not readily apparent because depression was often exhibited as boredom, restlessness, preoccupation with trivia, or acting-out behaviors.

Wellman (1984) described adolescent pre-suicidal behavior as a predictable five-stage process during which the adolescent attempted a variety of coping mechanisms as problems and stressors escalated. Wellman and Berman (1985) believed

the acting-out behaviors of alcohol or drug abuse, sexual promiscuity, and running away from home, to be coping mechanisms as well as manifestations of depression. Wellman believed the behaviors occurred in a progressive sequence, and could be used to assess the suicidal risk of the adolescent.

When alcohol or drug abuse is part of coping or acting-out behavior, it may become a means for the suicidal act. Renfro (1984) reported that from a study done by Ryser (1974 & 1980) of students treated in hospital emergency rooms, 50 percent used drugs for a suicide attempt or gesture. Renfro also cited Klagsburn (1983) who reported that the suicide rate among young alcoholics was 58 times higher than for normal population.

According to Wellman (1984) and Berman (1985), 80 percent of suicide attempters communicated their suicidal intentions verbally. Miller (1975), and Wellman interpreted verbal communications of suicidal intent as a "cry for help". Sometimes the cry for help consisted of verbal threats combined with experimentation with death (which Wellman called suicidal gestures). It was her view that these messages came from desperate young persons who were planning to move to more lethal methods if help was not forthcoming.

Adolescent Suicide Prevention

The most important finding from the literature review was that teen-age suicide is a preventable tragedy (Berman, 1985; Herbert, 1985; Ross, 1980; Wellman, 1984; and Ownby, 1985). These authorities plus Deykin (1984), Greuling and DeBlassie (1980), Grob et al. (1983), Farberow (1983), and Cosand et al. (1982) believed that the secondary school system is the most likely place for effective intervention and prevention education. There seemed no question that secondary schools would be expected in the future to play a larger role in adolescent suicide prevention. Only since about 1980 has the literature contained a few items dealing with direct crisis intervention and/or suicide prevention education programs which could be implemented in the secondary school system.

In general, the above authors expressed their beliefs that most high school professionals needed specific suicide prevention training, but that teachers' on-going relationships with their students provided an important opportunity to observe students who might tend to be suicidal and to assess the lethality of suicidal intention. The authors believed that trained faculty could be available to intervene in a crisis, either by referring the student to someone else, or by personally forming a therapeutic relationship. The faculty

could also provide follow-up contact to assess the likelihood of further suicide attempts.

Greuling and DeBlassie (1980) strengthened the rationale for placing preventive efforts in the secondary schools by calling attention to the fact that genuinely suicidal adolescents do not usually consult their family physician or a psychologist. Therefore, school teachers and counselors must be alert to students' suicidal tendencies if they are to receive any help.

Three examples were found in the literature regarding local school systems which set up school-wide adolescent suicide prevention programs in response to unusually high local adolescent suicide rates. After 12 teen-age suicides in one year, San Mateo County, California, conducted a one-year pilot program in 1977 for adolescent suicide prevention (Ross, 1980). In the Plano, Texas, school district, a suicide prevention program was organized after 11 suicides occurred in the 20 months from January 1983 to October 1984 by people aged 20 or under (Ownby, 1985). In Fairfax County, Virginia, an adolescent suicidal prevention program was organized in response to the 1980-81 school year in which the real number of student suicides for the year was over twenty (Herbert, 1985).

In the San Mateo County, California, program, Ross (1980) observed that school personnel were eager for help in dealing with adolescent suicide and that the students themselves were very interested in both the subject and the programs offered by the schools. Of significance were peer counseling programs that developed at several schools as an outgrowth of prevention programs, and the increased confidence of school personnel in management of suicidal students and in counseling of their own students following suicides in the community.

In evaluating the Fairfax County, Virginia, program as successful, Herbert (1985) pointed out that the one-year total of 20 suicides was dramatically reduced to three by the second year of the program. This was the inverse ratio to the national adolescent suicide death rate. Herbert found mental health and guidance personnel reported increased referrals of troubled students to their offices, and faculties and administrators had become more sophisticated in identification of troubled situations.

According to Ross (1980), the pilot project conducted in San Mateo County, California, included six high schools and one community college. This project was designed specifically to teach an understanding of the basic facts and concepts of suicidal crisis, ways school personnel could identify presuicidal behavior, and ways to respond helpfully and

effectively in such situations. Brochures were developed for school personnel and students and training kits and readings were recommended. Ross did not report the effect of this program on the frequency of adolescent suicide, however.

The Plano, Texas, school district took several steps to combat the problem of adolescent suicide; a district-wide parent involvement group was formed to improve communication with parents and to help them deal with their child's involvement with drugs or alcohol; two student groups were started to help students who felt lonely or left out of peer groups, and to use peer pressure in situations involving drugs, alcohol, or other improper activities; and a clearinghouse for individual information sharing was developed. The second thrust of the Plano program emphasized better communication and cooperation between the school system and already functioning community agencies. Co-operating community agencies included a 24-hour hot-line; trained deputy sheriffs who provided intervention, temporary commitment for safety, and immediate psychiatric involvement; and a provision that juvenile offenders could be placed in counseling rather than incarcerated for formal court action. Planned follow-up studies have not been published (Ownby, 1985).

The Fairfax County, Virginia, suicide prevention program was implemented by requiring in-service training for teachers

and by developing suitable programs through the Parent-Teacher Association (PTA) to get parents involved. Herbert (1985) reported that community professional agencies who were asked to conduct training for teachers and parents were very helpful and that programs aimed at parents and teachers were successful. During the first year, the Fairfax County suicide prevention programs for the students themselves were not very successful, however. Because of the caution of administrators, only one school presented a program which reached all students. In the second year of the program, a more indirect method was used in which small groups of students with "a problem" could work on a presentation with the counselor, and then serve on evening panel presentations for the student body, parents, and teachers. This approach reached all students and was believed to be more effective. In 1984, all 46 secondary schools in the system participated in the program.

The three examples above indicate what can be done by a highly-motivated local school system. Even though the programs were not implemented in the same way nor were they exactly alike, they were all viewed as helpful by participants. All three involved provision for direct crisis intervention when necessary, training in ways to respond effectively in crisis situations, increased knowledge of basic concepts concerning suicidal crisis, improved self awareness, and

provision for trained teachers and counselors to provide for on-going contact and counseling in both preventative and follow-up modes. They also provided for co-operative community referral where necessary. When the three programs have been operative for a longer period of time, it will be possible to assess their effectiveness.

In order to offer adolescent suicide prevention programs to all secondary students, the first and most difficult obstacle seems to be financial. Herbert (1985) testified that even though the schools may be the most dependable thing in some teen-agers' lives, they have inadequate preparation, personnel, or budget for the students' problems to be solved. She stressed that additional personnel should be added and that federal funds should be appropriated. Berman (1985) also regretted that there was no federal money appropriated to support either research or programmatic initiatives in the area of adolescent suicide.

Berman (1985) lamented the fact that only the two states of California and Florida have passed legislation to provide money to develop pilot youth suicide preventative programs in the schools. The financial burdens of any programmatic development, specialized training, or pilot programs within secondary schools have had to be borne by the local school districts.

The literature indicated that the second major obstacle to placing adolescent suicide prevention programs in secondary schools was that teachers and counselors need more training to successfully assume suicide prevention responsibilities. Grob, Klein, and Eisen's (1983) study of 80 high school professionals who dealt with suicidal behavior, revealed that respondents saw students and staff as attempting to be helpful when suicidal behaviors occurred, but saw families as often being defensive in their attitudes.

Respondents in the Grob et al. (1983) study believed the school should assume responsibility for the assessment of risk of suicide, referral within and outside the school system, and maintenance of contact and support. However, nearly two-thirds indicated that in-service training was needed to improve their skills for dealing with troubled and suicidal adolescents, and a number of respondents stressed that care be taken in selecting faculty to work with troubled students as some might "make things worse." Almost 50 percent stressed the importance of well-trained professionals to deal with troubled adolescents.

Gordon (1979) in a study of 1,739 geographically selected secondary school teachers from Dallas County, Texas, also found that teachers needed to learn more about adolescent suicide. Using a Likert-type scale, Gordon found that

secondary school teachers had a low level of knowledge about the problem of suicide and about teacher potential for intervention. Gordon considered these to be significant factors, perhaps causing the range of predominantly negative attitudes toward the problem of adolescent suicide. However, the teachers had a somewhat positive attitude toward the potential for teacher intervention. This finding agrees with Grob et al., (1983) respondents, almost three-quarters of whom wanted more training in dealing with adolescent problems, some of whom identified a specific need for better counseling skills, and almost all of whom believed they would personally find improvement in practical skills and usable information most helpful.

Based on the results of her above study, Gordon (1979) recommended that in order to increase teachers' knowledge and to improve their attitudes regarding adolescent suicide, curricula be devised for integration into existing pre-service and graduate education; in-service programs be developed and conducted; and that attention be given to the encouragement of constructive attitudes.

The third consideration discussed in the literature for implementation of an adolescent suicide prevention program into the schools is that provision be made for both immediate crisis intervention and long-term preventive and follow-up

help. Spero (1981) pointed up the dual nature of the problem presented by the suicidal adolescent. He suggested that there is the crisis proportion problem to be considered and given immediate attention, but that there is also an underlying psychological problem of long standing which should be analyzed and stabilized for long-term mental health. Rosenkrantz (1978) agreed with the idea that both crisis intervention and long-term therapy are necessary for suicidal adolescents.

Conclusion

The review of professional literature reveals that adolescent suicide is a national program which has escalated to become the second leading cause of death among adolescents in the United States. Very little has been done at either the national or state level to stop or to reduce it. California and Florida are the only states which have funded pilot programs. A few local areas in other states have instituted their own programs, and reported results from these programs were positive, or hopeful. However, so few fully-operative programs are reported in the literature, that one wonders if nothing is being done elsewhere, or if it is simply not being reported.

Published professionals agree that adolescent suicide is a very preventable death if the young suicidal can be observed

and treated in time. Most believe that it is more prevalent, more impulsive, and more easily predicted than is adult suicide.

The causes of adolescent suicide are multiple and individual. However, they are often characterized by a long-term psychological problem coupled with an increase of temporary stress which triggers an impulsive suicidal action. Depression is usually the underlying emotion involved in adolescent suicide, and is a very important indicator. It is sometimes disguised within several forms of acting-out behaviors.

Many authorities believe that although school faculties are not now adequately prepared to deal with adolescent suicide, the secondary school remains the most logical place in which to institute both crisis intervention and suicide prevention programs. Pilot programs indicate that high school faculties' general experience with adolescents, their concern for their students, plus their daily contact with students make them the first choice for training in adolescent suicide prevention techniques. Once trained, indications are that teachers and counselors do very well in assisting with the prevention of adolescent suicide.

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