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Adolescent suicide: An investigation of causes and prevention measures

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Abstract

Suicide is not a recent phenomenon among adolescents. Young people have taken their own lives for as long as history has been recorded. It is not coincidence, or by accident, that literature, too, is full of reports of adolescent suicides (Konopka, 198J). Ophelia drowns herself after she is rejected by Hamlet. Romeo kills himself when he believes his beloved to be dead, who in turn kills herself when realizing Romeo had committed suicide.

ADOLESCENT SUICIDE: AN INVESTIGATION OF CAUSES AND PREVENTION MEASURES

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THE PROBLEM

Introduction

Suicide is not a recent phenomenon among adolescents. Young people have taken their own lives for as long as history has been recorded. It is not coincidence, or by accident, that literature too, is full of reports of adolescent suicides (Konopka, 1983). Ophelia drowns herself after she is rejected by Hamlet. Romeo kills himself when he believes his beloved to be dead, who in turn kills herself when realizing Romeo had committed suicide.

Throughout history, society has passed harsh judgment on persons who have committed suicide. In most cultures society has been greatly influenced by religious doctrines. Regardless of individual creeds, taking one's own life interferes with the plan of the deity (Ray & Johnson, 1983). Many religious groups view the act of committing suicide as self murder.

With the growth of the Christian and Islamic religions, suicide continued to be regarded as totally unacceptable and therefore hidden in mystery and secrecy. This was the reason many of the deaths, which possibly could have been suicides, were obscured by explaining that the cause of the death was an accident, murder, or

simply unexplainable (Miller, Chiles, &Barnes, 1982). These same excuses are still being used. Today the official report may state the cause of death as "accidents occurring from automobile accidents, drug overdoses, accidents occurring from firearms, or some other form of accidental death" (Ray &Johnson, 1983). Because of the falsification of coroner and/or police records, accurate suicide statistics are not available.

Although the true reason for adolescent deaths may be difficult to document at times, research suggests that the suicide rate of adolescents has been increasing in recent years (Cohen-Sandler, Berman, and King, 1982). About 12,000 children, ages 5-14, are admitted to psychiatric hospitals for suicidal behavior every year, but this number could represent less than five percent of the children who actually attempt to commit suicide (Turkington, 1983).

Teenage suicide is a real and frightening problem. The causes of suicide and the signs and symptomatic behavior of suicidal persons need to be identified and examined in order to seek solutions for prevention and treatment. Also, parents, teachers, and counselors need to become more aware of the children and students who are potentially suicidal.

Statement of the Problem

A major concern facing society today is the rapid increase in the rate of adolescent suicides. The suicide rates have dramatically increased since the 1960's. Data indicates that in the United States in 1957, 4.0 of every 100,000 adolescents committed suicide. This rate increased to 10.9 of every 100,000 adolescents committing suicide by 1974, and in 1975 the rate of adolescent suicide jumped to 12.2 of every 100,000 adolescents (Matter & Matter, 1984). This shows an increase of 300 percent in adolescent suicide from 1960 to 1975. This increase should arouse the parents, teachers, and counselors of our society to try to ascertain the reasons adolescents feel that life is not worth living, or that death is the best solution to their problems.

Calvin Frederick, chief psychologist at Veteran's Administration Medical Center, Brentwood, California, reports that an average of five teenagers commits suicide daily in the United States. With these kinds of statistics, society needs to become more aware of the problem and seek ways to reverse the trend.

The problem to be addressed in this paper is an identification of possible causes of adolescent suicide, prevention and treatment for suicidal adolescents, and

ways to make parents, teachers, and counselors aware of these causes and prevention techniques.

Procedure in Obtaining Research Literature

In obtaining related literature and research, extensive use was made of the Educational Resources Information Center (ERIC) documents. This type of research included the use of the Current Index to Journals in Education (CIJE), and the use of Resources in Education (RIE). The Educational Index was also an aid in locating needed literature. The journal articles, magazine articles, and research articles were then obtained from either the University of Northern Iowa Library or the Englebrecht Library, Wartburg College.

After obtaining many of the materials and reviewing the literature, a further search for related information was conducted for literature suggested in the bibliographies of previously gathered literature.

This information was then organized for further investigation into the following major areas related to the problem: myths and facts about suicide, causes and signs of adolescent suicide, prevention of suicide, and treatments available for schools to implement for potential suicidal adolescents.

REVIEW OF THE LITERATURE

Myths and Fallacies About Suicide

There are many preconceived thoughts about suicidal victims, many of which are untrue and biased. These attitues about suicide need to be exposed in order for the suicidal victim to obtain the needed counseling and medical attention.

One of the most misinterpretted statements of suicidal persons, including adolescents, is the belief that those people who talk about committing suicide never do (Conger, 1977). Hyde and Forsyth (1978) state that as many as 60 percent of the people who commit suicide had, at one time, made some definite statement about taking their own life.

In many cases, adolescents act upon impulse rather than reason. They do not always conceive a situation as a whole. Sometimes this lack of maturity restrains the adolescent from perceiving the final outcome of suicide as being irreversable. In most cases the suicidal act is a sudden impulsive reaction to a stressful situation (Ray & Johnson, 1983). Therefore, the threat of committing suicide should be interpretted as a cry for help. According to Morris and Bedal (1982), the true reason that youths talk about death is that they are desperately hoping that someone

will hear them and help them through the difficult period of their life. Often, this cry for help is not heard or acted upon, and the suicide attempt is completed. Consequently, no true suicidal threat should be taken lightly.

Another suicidal myth is that "once a person is suicidal, he is suicidal forever" (Schneidman, Farberow, & Litman, 1976). Individuals who wish to kill themselves are only suicidal for a limited period of time. Persons who feel like killing themselves are usually going through a dramatic time in life. They need to learn how to cope with this stressful situation. After learning how to cope with one stress, suicidal persons realize that they made it through a rough time, and they learn that other solutions, besides death, are available (Rosenthal, 1983).

Suicide is not limited to those people who are wealthy, poor, or have had another family member commit suicide. All kinds of people end their own lives regardless of age, sex, race, economic background, mental, or physical state (Ray & Johnson, 1983). Suicide does not run in the family (Ray & Johnson, 1983). Research has yet to document that suicide is hereditary (Kosky, 1983). Although, experiencing a suicide by a family member can subconsciously introduce the

idea of suicide. A feeling of guilt frequently accompanies the suicidal death of a family member. Because of these feelings, the children and adolescents who have experienced the suicide of a family member need to be monitored and helped to eliminate the feeling of guilt. Suicide knows no class or distinction.

"All suicidal individuals are mentally ill, and suicide is always the act of a psychotic person" is another fallacy frequently attributed to suicidal individuals (Schneidman, Farberow, & Litman, 1976). Studies of hundreds of genuine suicide notes show that persons who take their own life are often extremely unhappy. Being unhappy does not imply mental disorders. The state of despair or sadness can be caused by loneliness or a variety of other human conditions.

Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them (Schneidman, Farberow, & Litman, 1976). Very few people commit suicide without letting someone else know how they are feeling. Therefore, "suicide people are intent on dying" is also a myth. Some adolescents use suicide attempts to gain attention or control and never really intended to complete the act (Matter & Matter, 1984).

Causes and Signs of Adolescent Suicide

Adults seem to remember adolescence as being a trouble-free time of life. Adolescents are viewed as persons who have everything they could want. The typical middle-class teenager has a car, money to spend, friends, and few adult responsibilities.

Contrary to this "rose garden" picture that adults frequently create, the adolescent years are a time when a youth undergoes a significant number of changes. This is the time of life when adolescents experience many things for the first time. Because these experiences are new, the general feeling of the adolescent is that no one else has ever experienced this before, or that no one else could have had an experience as traumatic as this.

This period of growth, adolescence, is mentally, physically, emotionally, and socially characterized by many rapid changes (Hankoff & Einsidler, 1979). Rapidly developing biological and sexuality changes create fear and confusion for the adolescent. Often, having too many changes at the same time and having them happen so quickly in the youth's life makes it difficult for the adolescent to cope (Hankoff & Einsidler, 1979).

One of the most common causes of suicide is depression (Kosky, 1983). Depression can be caused by a chemical imbalance in the brain or from some other physical malfunction. Social interactions, which bring about despair, can cause adults and adolescents to go into a depressive state of mind (McBrien, 1983). The feeling of failure, or loss of a love object, also brings much hurt into an adolescent's life. This feeling of failure can be caused by the adolescent being rejected by someone, or something, (McBrien, 1983). Adolescents experience depression for the same reasons that adults do. A major difference in the outcome, however, is that the youth lacks the experience of making decisions with good judgment, and the adolescent who is feeling despair, reacts more quickly and easily to the suggestion or thought of suicide (Hyde & Forsyth, 1978).

The same symptoms of depression occur with adolescents as adults (Ray & Johnson, 1983). These symptoms include a feeling of hopelessness, low self esteem, abrupt behavior changes, sleep disturbances, fatigue, loss of energy, and a loss of or an increase in appetite. Indications of adolescent depression also include delinquent behavior, sexual promiscuity, and drug and alcohol abuse.

Adolescents attempt to keep their depression hidden. Often the depressed condition is misinterpretted as "just a phase" through which the teenager is passing (Hyde & Forsyth, 1983). What is noticed as symptoms are merely the methods that adolescents use to release their emotion. These symptoms are, therefore, indicative of ways in which adolescent depression can be recognized.

A highly significant factor in the behavior of adolescent children is the loss of a parent or parenting figure. A research study by Cohen-Sandler, Berman, and King (1982) indicated that the loss of a parent through divorce, medical illness, or death, and the loss of a grandparent are significant factors in the lives of suicidal children. The loss of the parent or parenting figure may be viewed by the child as rejection. These feelings may then turn to feelings of guilt or uselessness. This loss of the role model may then foster inadequate behavior patterns (Hawton, 1982). The loss of a parent does not always lead to attempted or completed suicide. In most cases the adolescent can adjust to the situation. This is accomplished when the child realizes that the death of the role model is an irrevocable situation.

The ability to adjust seems to depend on numerous things in the adolescent's life. The nature of the loss, the developmental stage of the child, the ego strength, the amount of independence already acquired by the adolescent, and the support system of the remaining family members (Ray & Johnson, 1983).

In societies where family ties are close, suicide rates are low, and where family ties are not as close, the rate of suicide is high (Morris & Bedal, 1982). Because of the change in the traditional home, there seems to be a growing lack of communication (Ray & Johnson, 1983). No longer is it true that the stereotypical family consists of the father at the head of the household, the mother the keeper of the home, and children. Instead, it is now the exception to the rule. The family unit is being broken apart by the rising divorce rates, the increasing number of working women, and the rapidly rising number of women as heads of households.

The breakup of the traditional family, along with the smaller family size, has made it difficult for a family member to be available when the youth needs someone with whom to talk. In previous generations families had large numbers of children, and generally, the mother worked in the home. This allowed for many opportunities for the adolescent to have some available member of

the family available with whom to talk and receive help with the problem.

The alienation caused by the new family model often results in the youth withdrawing from other family members, and not taking advantage of the opportunity to discuss the problem when another family member returns home. Withdrawal is not always just from family members; sometimes it is a withdrawal from friends (Ray & Johnson, 1983).

Many adolescents have said that they would confide in a friend if they were feeling depressed or were considering suicide (Pinkston, 1983). This continues to demonstrate the affect of the breakup of and alienation from the family.

The family compounds the feeling of alienation when it places pressure on the adolescent to succeed in school work, athletics, music, art, or some other talent. Sometimes this pressure is placed on the youth to succeed in social relationships. The expectations placed on the youth of today are very high (Konopka, 1983). Today, the world demands understanding and acceptance of different types of lifestyles. Some youths have to learn to live with homosexuality, people living together without the bond of marriage, and inter-racial marriages.

The United States is considered a place where people are given an equal opportunity to achieve success,

but it is also a highly competitive and achievement oriented society. American youths learn this early in life and feel the pressure to gain recognition for something they can do well, or they are considered a failure. Failure to achieve can be painful. A youth will choose a way out of such a situation by: accepting the situation, choosing social isolation, or in extreme cases committing suicide as the only other alternative (Hawton, 1982).

Our culture has not learned how to help its youth cope with pain (Konopka, 1983). Education even displays this philosophy of "no pain" through its behavior modification techniques. This philosphy rewards persons who are good (Konopka, 1983). This attitude towards rewarding goodness leads some adolescents to feel that they have done something wrong, or bad, since pain is the feeling they are experiencing. It is impossible to try to condition everyone for all of the different kinds of experiences which they will need to handle. Yet, it is healthier to prepare them for the pain that will be experienced and may arise in everyday situations (Konopka, 1983).

The pain that the adolescent is feeling is real. It may seem like an unending problem. It often appears that every time life seems to be under control something

happens to destroy that feeling. At times like these the adolescent needs someone with whom to talk, and often the youth debates whether or not an adult will truly understand the problem. Adolescents have a great fear that their problem will be ridiculed or not taken seriously (Konopka, 1983). These fears lead to the belief that there really is a generation gap. Adolescents feel that only someone their own age will be able to understand the deep problem they are facing.

Adolescents feel pressure from several sources: they feel pressure of their peers, pressure of changing moral standards by which they have always lived, and the pressure of their own conscience. They are pulled in many directions when they try to sort out their feelings or attempt to make a right decision. When adolescents no longer feel adults understand what is happening, they begin questioning the values that they have been taught. All of these problems become another source of the feeling of indecision, fear of making the wrong choice, and wish that they still had someone dictating the proper choice.

While gaining independence from parents during the adolescent years, a youth experiences the loss of the security that was felt up to this point. Even

though the adolescents wish to make decisions and become more independent, having someone there telling them what they can or cannot do provides more security.

Adolescents seems to be preoccupied by the thought of death (Grob, 1983). They talk about death, and their talk about death often leads to discussions about suicide (Pinkston, 1983). There seems to be a fascination with death, and youths presently imagine death as a temporary state where it is problem-free and pleasant (Grob, 1983).

The adolescent does not realize that the choice of death is an irreversible decision and once this route has been chosen there is no turning back. The choice of death is not generally chosen as a solution to the problem, but it is viewed by the youth as being a pleasant experience (Grob, 1983). Death has been pictured as restful and peaceful with no problems. There is to be no more pain or unpleasant situations. Therefore, when the adolescent is going through true turmoil the consequences of death appear to be a simple and satisfying solution. What needs to be instilled within the adolescent is that there is no turning back once the decision of suicide has been made.

The problems that adolescents face today are critical. World problems demand a great understanding.

The interrelationships between the United States and countries all around the globe place a tremendous amount of pressure on the adolescent to be aware of world situations (Konopka, 1983). Being so involved with world problems, our society is experiencing continuous changes and uncertainties (Ray & Johnson, 1983). Today's youth are more aware of the world situations because of improved media.

The media supplies information using a style that arouses people. This procedure generally affects the youth more readily than the adults since the adolescent is so impressionable. The result of this media impact is that it gives the youth a "dooms-day" outlook upon life (Konopka, 1983). The adolescent does not generally feel any reason to go on living since there probably will not be a world left when adulthood is reached.

The job and unemployment outlook also gives the youth a feeling that there is very little for which to look forward. All of the jobs are already taken, and with unemployment so high a job will be almost impossible to obtain (Konopka, 1983). These different reasons for suicide reinforce the choice as a viable alternative.

The causes of suicide can be recognized through four types of warning signs (Ray & Johnson, 1983). Some of the signs are fairly obvious while others are more difficult to detect. One of the signs, which is probably considered the most obvious yet often overlooked, is the verbal sign (Ray & Johnson, 1983). This is frequently dismissed because it is viewed as an "empty threat." Verbal statements such as, "I wish I were dead," or "You won't have to worry about me anymore," can be significant warning signals. These statements can be true feelings of the suicidal individual (Conger, 1977).

Other, more indirect statements, such as "How do you leave your body to science?" or "Why is there such unhappiness in life?" are also worthy of notice (Conger, 1977). Neither of these two types of statements should be taken lightly. The two types of statements are typically spoken by suicidal individuals.

A second type of warning sign is classified as a behavioral sign (Schneidman, Farberow, & Litman, 1976). An example would be an attempted suicide. The attempt may be considered weak, yet it is a sign that the child is serious. When an attempt is made, the youth may be looking for or demanding attention, but if nothing is done a more serious attempt is liable to

be taken (Ray & Johnson, 1983).

Another signal that youths are feeling stress is when they begin to give away prized possessions (Matter & Matter, 1983). This indicates that the youth cares very little about what is happening in the world and does not really care to stay around. Turkington (1983) presented the example of a six-year-old girl who killed herself to join her grandparent and left no evidence that she intended to be alive on Monday. She left nothing undone.

Sudden changes in attitudes and behavior is another signal of a suicidal adolescent (Miller, 1975). These changes include an "I don't care" type of attitude. It would appear that the adolescent feels that nothing is very important. Also, any erratic behavior that seems to have no rational explanation, excessive irritability, complaining of small annoyances, inability to concentrate, crying, difficulty making decisions, and excessive feelings of guilt are all signals that the youth is having problems coping.

The third type of warning sign is categorized as situational signs (Schneidman, Farberow, & Litman, 1976). These signs include major events that have happened in the adolescent's life. This would include

a loss of a parent, alienation from the family, or a problem caused by today's "typical" family. These situations are ones in which the adolescent must decide how to best cope with the problem. The adolescent may also have difficulty coping with the loss of a job, loss of a love object, chronic illness, or change in address. Sometimes these events in an adolescent's life appear to that individual as being life threatening. Although these are not always the cause of death, they may serve as indicators of possible suicide attempts (Ray & Johnson, 1983).

The fourth type of warning signal is the syndromatic sign (Schneidman, Farberow, & Litman, 1976). The most common is depression. Because depression is one of the leading causes of suicide it is important to recognize the clues or characteristics of depressed young people (Ray & Johnson, 1983). The symptoms include: sleep disturbances, excessive fatigue, loss of or increase in appetite, feelings of hopelessness, despair, low self-esteem, and abrupt behavior changes. Defiance or a desire to control their own destiny is another symptom in the syndrome. A condition in which people hear commands to destroy themselves, disorientation, is another symptom (Schneidman, Farberow, & Litman, 1976).

Treatment and Prevention

Treatment and prevention practices for suicidal persons are practices that are presently being used with victims of unsuccessful suicidal attempts. Family members of the suicide victim or person who has attempted suicide are also treated. The prevention procedures apply to those youths who have suicidal tendencies.

Treatment for the adolescents who attempt suicide can be separated into three categories. These categories are biophysical, psychological, and sociological (Ray & Johnson, 1983). The first of the three, biophysical, is the area in which the medical profession is most interested. Medical doctors use a combination of hospitalization and chemotherapy in treating such patients. The most recent treatment is the use of the drug, lithium (Den Houter, 1981). This drug affects the emotional stability of the potential suicide victim. Studies have shown significant improvement in the well being of individuals between the ages of 15 and 20 years who have received this drug (Ray & Johnson, 1983).

The psychological aspect of treatment relies on the therapist and the adolescent. The therapist's job is to help adolescents cope with their problems and enable them to confront personal concerns (Den Houter, 1981).

This can occur only when the therapist and the adolescent have established mutual trust. The therapist will either work individually with the adolescent or involve him/her in group therapy. The adolescent's personality will determine the type of treatment (Den Houter, 1981).

The sociological perspective determines treatment when the environment is the major cause for the suicide attempt. Treatment involves the social worker, the family, and the adolescent in the therapy sessions (Ray & Johnson, 1983). Because the family situation is directly associated with the causes of suicide, it is important that parents, and other family members, participate in the therapy.

When an adolescent suicide does occur it is important that the family survivors go through postvention treatment (Den Houter, 1981). Survivors experience a grief process in which they first exhibit disbelief, followed by sorrow, and then, frequently, guilt (Den Houter, 1981).

Prevention of suicide requires intervention from teachers and counselors since the parents and friends are usually too intimately involved. The teacher or counselor can be more objective, and should be aware of changing behavior patterns that provide clues to potential suicides (Ray & Johnson, 1983). The first

step in prevention is to keep the lines of communications open. The parent, teachers, and counselors need to listen (Konopka, 1983). Adolescents want to talk to adults, but often they feel rejected. Adults should view adolescents as people. One cannot refer to adolescent relationships in terms such as "puppy love," and expect them to feel the adult truly understands.

By treating the adolescent as a person and showing love and respect, a trust relationship develops (Konopka, 1983). Adolescents do have good ideas and sharp minds with which to examine personal values. By allowing adolescents to recognize that adults also make mistakes, they can improve self-concepts. They need to realize that they are not alone in exercising poor judgment.

Allowing creative outlets for the emotions of youth is a way which adults can help them confront personal problems (Konopka, 1983). Through writing, poetry, art work, acting, music, and other types of creative expression, adolescents can find a release for tensions. Adults need to encourage this type of outlet.

Just talking about pain and sorrow is not enough for the adolescent (Konopka, 1983). The adult needs

to allow youths to examine the pain which they are experiencing. By recognizing the pain experienced by the adult, the adolescent understands that the pain is real, and that the adult was being honest when telling the youth that disappointment is an integral part of life.

Discussion of suicide does not necessarily cause depressed students to be more inclined to take their lives. Usually they are emotionally relieved (Pinkston, 1983). The discussion of suicide actually tends to moderate the likelihood of serious attempts (Pinkston, 1983).

In order to further educate the public about suicide prevention, the American Association of Suicidology was founded. The organization sponsors workshops, awareness programs, and distributes publications. The main goal is to educate the public about suicide prevention and crisis intervention services which are available in local communities (Hyde & Forsyth, 1978).

SUMMARY AND CONCLUSIONS

Adolescent suicide has been rising at an alarming rate for the past 20 years. The acceleration has brought the topic to the attention of many researchers who have been investigating causes, symptoms, treatments, and prevention.

The principal causes of adolescent suicides have been determined to be depression, loss of a love object, societal pressures, and alienation from the family.

Because family members and friends are so intimately involved with the adolescents' personal problems, teachers and counselors need to take a more active role in the prevention processes. They should be alert to the changing behaviors in adolescents. If society begins to rely on teachers and counselors to identify potential suicidal students, some type of inservice must be provided.

To educate the public about suicide prevention, the American Association of Suicidology was founded. This organization sponsors conferences, produces publications for general distribution, and conducts awareness programs. Suicide prevention centers have been established, and are staffed 24 hours a day, seven days a week. These services operate by telephone, and the worker tries to provide emotional support to potential victims during critical stages of despondency.

On March 3, 1983, the legislature in California passed Senate Bill 947 which states that all public schools will offer a program dealing with suicide. It was entitled "School Youth Suicide Prevention Pilot Program." The American Association of Suicidology is now trying to encourage other states to pass similiar laws.

Adult education classes are also offered in some communities. These classes are designed for teachers, nurses, social workers, and parents.

Because young people are the leaders of the future, it is important for parents, teachers, counselors, and peers to be alert to symptoms of suicide. Through awareness of the causes and signs of adolescent suicide, lives can be spared and the full potential of future citizens realized.

Research into suicidal behavior of children must continue. In the meantime, families can be taught better communication and child rearing skills, and teachers and counselors can become more alert to students' behavior changes so that intervention can occur.

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