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# Youth and suicide

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## Quick Facts

- In a Colorado State University Cooperative Extension study, "rising youth suicide rates" ranked ninth most critical social and economic issue from a list of 33.
- Colorado's suicide rate for 15- to 24-year-olds has exceeded the national rate every year since at least 1970.
- Friends and family members can learn to identify early warning signs of youth depression and suicide.
- By knowing how to respond gently, yet firmly, friends and family members can *help* young depressed friends choose to live.

Suicide in youth is the second leading cause of death – second only to accidents – and more prevalent than homicides. Every year in the United States 250,000 youth attempt suicide (Wade, 1987). Of those in the 15 to 24 age group, 5,000 will die per year. This means that every day close to 14 of our young people will die by suicide (Abbey, Madsen and Polland, 1989). It also is known that children under 15 think about, attempt and complete suicide. The frequency goes up with age. Most experts believe, however, that many suicides can be prevented with parents and those interested in youth acting as the first line of defense in stopping this fatal act (Hamilton-Obaid, 1989). In order to prevent a young person from attempting suicide, it is essential to know the causes, warning signs, and what to do if one suspects suicidal thinking.

Colorado ranks 20 percent above the national average in reported adolescent suicides. The issue of youth suicide rates being three times higher in 1990 than in 1970 (Jenson and Warstadt, 1990) was ranked *ninth* most critical of 33 youth and family social and economic issues by a random sample of Coloradans (Fetsch and Yang, 1990). The Denver - Boulder area has the highest teenage suicide rate of any metropolitan area in the country (Forrest, 1988). Colorado's suicide rate for 15- to 24-year-olds has exceeded that of the nation every year since at least 1970 (Colorado Department of Health, 1987).

According to the Division of Vital Statistics and the Bureau of the Census, over the last 26 years reported suicide rates increased 200 percent for girls and 300 percent for boys, ages 15 to 24, while

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across the lifespan, the national suicide rate remained the same. It is believed that the increase in adolescent suicides relates to: 1) poor outlook for success in the future, 2) increasingly fast-paced society with youth feeling unprepared for too many changes and options, 3) pressure to succeed, 4) lack of support systems; 5) and family alienation (Blumenthal and Kupfer, 1988; Forrest, 1988).

Adolescence is filled with many changes and is a vulnerable time for youth. There are great changes in physical characteristics, changes in the way they think, changes in expectations placed on them, increasing responsibilities, and the move toward greater independence. Becoming more independent of adult support and care is one of the hardest things for a youth to do. On the other hand, it is one of the most important developmental tasks for a youth to accomplish. These twin motivations often lead to great emotional anxiety. Lots of understanding is needed.

The way adolescents think is unique and can contribute to suicide. Of particular importance is their egocentric thinking identified as "personal fable thinking" (Muuss, 1988). Adolescents are prone to exaggerate the importance or significance of their own thoughts and feelings. This often leads them to believe that they are completely unique, that there is no one like them or no one who has experienced the intensity of their feelings. Also, some families' communication rules do not permit the suicidal person to state his or her needs openly to others. Thus, there is no one who can understand them. This often creates a sense of intense aloneness and isolation as they face problems. Furthermore, the personal fable often relates to a belief that they are indestructible. Their belief that no one can understand them leads to feelings of loneliness and the decision not to seek needed help. Furthermore, many youth believe that suicide is somehow romantic or heroic. They may fail to comprehend that death is irreversible and perceive death like a peaceful sleep that will make everything better.

In today's adolescents, at least 65 percent have thought about suicide (Diekstra and Hawton, 1987, p.10). Some thoughts are not very serious, others are. Adolescents often have few life experiences and poor problem-solving skills. Their thinking is present rather than future-oriented. They have needs for immediate solutions. Many adolescents mistakenly believe that suicide is an acceptable solution to problems.

Some of the *reasons youth give for thinking of suicide as a solution* to problems are: to make others feel sorry, to make others know how desperate they are, to influence others, to make the pain go away, not knowing what else to do, to show how much they love someone, revenge, to make things easier for others, to be with someone who died, to die (Diekstra and Hawton, 1987).

*Depression is the leading cause of suicide*, suicide attempts, and suicidal thinking in youth (Forrest, 1983; Martin and Dixon, 1986; Neiger and Hopkins, 1988; Ray and Johnson, 1983; Stivers, 1988). It is critical to be able to recognize the symptoms. Depression may be more concealed in the adolescent and viewed as a **phase** related to the frequent mood swings often experienced by adolescents. Having the **blues** can be a normal experience when it doesn't last long. When it is long-term and intense it is identified as depression. Some factors related to depression are events perceived as losses with negative meanings. Some examples of events perceived as losses are: loss of a loved one or a relationship; unwanted pregnancy or abortion; events that lower self-esteem (school expulsion, failure to make a team, academic failure, or not being invited to a popular social event, Stivers 1988). Any one of these events can be seen as either an opportunity or a crisis. When youth experience little or no control in the important events of their lives, they may see themselves negatively. "I'm worthless. I'm no good." This negative thinking makes it difficult for youth to face the stresses in their lives, and combined with poor problem-solving skills can lead to feelings of depression and hopelessness (Deal and Williams, 1988; Elkind, 1986; Patros and Shamoo, 1989). Thinking and behavior tend to go together. Some of the *behavioral symptoms of depression* in adolescents include: acting-out, delinquency, anger, sexual promiscuity, alcohol and other drug use, withdrawal from normal activity and social contact, sleep disturbances, decreased or increased appetite, drastic changes in appearance, loss of energy (Forrest, 1983; Martin and Dixon, 1986; Patros and Shamoo, 1989; Ray and Johnson, 1983).

Not all depressed youth try to kill themselves. But, the majority of youth who do attempt suicide experience depression.

Alcohol and other drug use can increase the risk of suicide, especially if used to escape pain. The substances create a change in consciousness. When this change no longer allows them to escape their pain, they may resort to a more drastic measure, suicide. Those involved in substance use tend to be more impulsive, easily frustrated, and lacking in self-control. In conclusion, the substance itself may be the chosen method of suicide (Neiger and Hopkins, 1988).

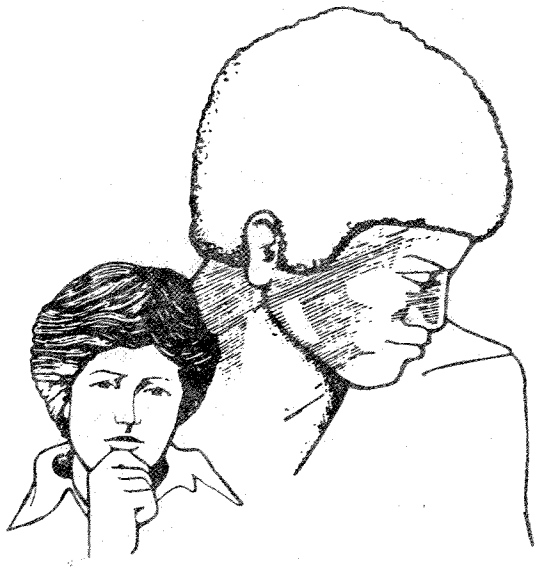

**Table 1. Warning signs.**

**Verbal**

"I wish I were dead."

"You don't have to worry about me anymore."

"How do you leave your body to science?"

"Why is there such unhappiness in life?"

**Behaviors**

Previous suicide attempt.

Giving away prized possessions.

Arranging to donate organs.

Making a will.

Alcohol or other drug use.

Careless, risk-taking behavior.

Withdrawal from family and friends.

Running away from home.

Change in school performance.

Extreme irritability, guilt, crying, inability to concentrate.

Violent and rebellious behavior.

Collecting pills, razor blades, knives, ropes, or firearms.

**Feelings**

Depression.

Sadness.

Loneliness.

Extreme boredom.

Sudden happiness after long period of depression.

**Situations**

Recent suicide or death of someone a youth respects or is close to.

Being a victim of physical or sexual abuse or rape.

Troubled family life.

Social isolation, lack of close friends.

Recent loss of job, friendships.

Failing or dropping out of school.

Not making a team or membership in an organization.

Unwanted pregnancy or abortion.

Being a "perfectionist." (Diekstra and Hawton, 1987; McBrien, 1983; Neiger and Hopkins, 1988; Ray and Johnson, 1983; Patros and Shamoo, 1989).

The majority of youth who complete, attempt, or think about suicide give signs of their intentions. However, they may give different signs to different people, making it difficult to put all the signs together. That is why it is so important to pay attention to *any* signs that indicate a youth may be having thoughts of suicide (Patros & Shamoo, 1989).

There is no complete list of symptoms for any youth. There is usually no single cause or a signal of suicide or suicidal thinking. Trying to determine whether a behavior is typical of adolescence or of serious concern often is difficult. If you suspect that a youth in your family, or a friend may be suicidal or experiencing depression, you may feel scared, nervous or anxious. These are normal feelings to experience. Following are some general guidelines on what to do and what not to do when you find yourself concerned about a young person's being depressed or suicidal.

- Do take all threats seriously.
- Do notice signs of depression and withdrawal.
- Do be concerned if there is recent loss in the youth's life.
- Do trust your own judgement.
- Do tell parents, guardians, guidance counselors, etc.
- Do express your concerns to the youth by being an active listener and showing your support.
- Do be direct. Talk openly and freely and ask questions about the person's intentions.
- Do try to determine if the person has a plan for suicide (how, when, where). The more detailed the plan, and the more deadly the means, the more serious the threat.
- Do, if safety permits, remove the means of suicide.
- *Get professional help.* Seek help from a school counselor, family therapist, psychologist, physician, trusted minister, priest, rabbi, or crisis center to help solve the problems. Stay in close touch with the youth. Post community resource numbers by the phone: police, poison control, fire department, local crisis help-lines, mental health centers.
- Don't ignore or explain away suicidal behavior or comments.
- Don't ignore verbal and behavioral warning signs.
- Don't assume that a youth will easily get over a loss.
- Don't be misled.
- Don't be sworn to secrecy.
- Don't attempt to impose guilt by preaching or debating the rightness or wrongness of suicide.
- Do not act shocked at what the youth may say to you.
- Do not assume that the youth will be all right left alone.
- Don't leave the means of suicide available to a youth.
- Don't assume because others become involved that the youth no longer needs your help.

(Cherry Creek School District #5; Patros and Shamoo, 1989)

The primary purpose of professional intervention is to assess the seriousness of a youth's situation and help them and their families through the crisis. Immediate action will depend on the professional's assessment of the situation. It is

most important for all involved to realize even though the initial "suicide crisis" may have passed, the problems and feelings that brought the youth to suicidal feelings still exist. A plan of action is needed that includes counseling or therapy for the youth and their family. The youth and the family need assistance in self-esteem building, problem-solving, and developing new and better ways to communicate. Treatment programs for young people who suffer from self-destructive thinking cannot be successful if short-term or individual-oriented in nature. They require professional intervention that meets the youth and their families with consistent respect, care, concern and interest (Peck, Farberow and Litman, 1985).

## Myths and Facts About Youth and Suicide

MYTH: Adolescence is a trouble-free time of life.
FACT: Adolescence can be the most "roller-coaster" time of life.

MYTH: People who talk about committing suicide never do it.
FACT: When someone talks about committing suicide, they may be giving warning signals that should not be ignored. It is a way of asking for help.

MYTH: Talking to someone about their suicidal feelings will cause them to commit suicide.
FACT: Asking someone about their suicidal feelings may help the person feel relieved that someone finally sees their emotional pain.

MYTH: People who make suicide attempts are only looking for attention.
FACT: Suicide is an indication that all other ways they know of getting help have failed.

MYTH: There is a typical type of person who commits suicide.
FACT: The potential for suicide exists in all of us. Prior suicide attempts or suicidal behavior in the family can increase the risk.

MYTH: Improvement following a suicidal crisis means the suicidal risk is over.
FACT: Most suicides occur within about three months following "improvement." Having made a suicide decision, they may feel relieved that the pain will end.

MYTH: All suicidal individuals are mentally ill, and suicide is the act of a psychotic person.
FACT: Although this person is extremely unhappy, they are not necessarily mentally ill.

MYTH: All suicidal people want to die and there is nothing that can be done.
FACT: Most suicidal people are ambivalent, that is, part of them is saying "I want to die," and part is saying "I want to live."

MYTH: All suicides occur without warning.
FACT: Many people, including adolescents, give warning of their suicidal intent (Martin & Dixon, 1986; Patros & Shamoo, 1989; Ray & Johnson, 1983).

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