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ABSTRACT

The adolescent at risk for suicidal preoccupation and behavior has become an increasing concern for schools and communities. This paper presents some of the causes of teen suicide, things adults should know about adolescent suicide prevention, and what can be done to help such youth. The transition to adolescence is a complex time when many values may be questioned. Family dysfunctions, such as poor communication skills, resistance to grieving, difficulties with single parenting, and abusive interactions can further confuse this already difficult period. Likewise, environmental pressures, such as academic achievement, constant mobility and the availability of drugs, can lead to depression and the inability to cope with stress. It is emphasized that knowledge is the most effective tool in preventing suicide. Adults should be aware of the myths associated with suicides, such as the myth that adolescents who talk about suicide never actually attempt suicide or that suicide is hereditary. Adults also must be able to recognize the profile of the suicidal adolescent so that referral and intervention can take place. Included in this profile are behaviors, such as a lack of concern about personal welfare, verbal cues, and altered behavioral patterns and personality traits. Adults can help an adolescent who manifests an interest in suicide by expressing their concern for the child, developing a rapport, and facilitating a meeting with a counselor or crisis team member. (RJM)

PREVENTING ADOLESCENT SUICIDE

David Capuzzi

PREVENTING ADOLESCENT SUICIDE:

AN INTRODUCTION[1]

The adolescent at risk for suicidal preoccupation and behavior has become an increasing concern for schools and communities throughout the United States. Adolescents are increasingly at risk of committing suicide, on average one young person commits suicide every 90 minutes, making suicide the second leading cause of death (Hayes & Sloat, 1988).

Understanding The Causes

The Adolescent Transition

Adolescence as a stage in psychosocial development has become more complex, more stressful and more prolonged than ever before. Choices about whether to use drugs, to join gangs, to experiment sexually, or to pursue a vocational or academic course of study must be made earlier and earlier amidst escalating pressure and confusing options. These choices prove to be difficult even for adolescents who are successfully mastering the essential developmental task of separation and identity formation. Successful separation and identity formation can only occur, however, when children and adolescents have been exposed to positive adult models for parenting and nurturing. As adults become more and more focused on earning a living in a country in which the cost of food, clothing, housing, medical care, etc. has increased more rapidly than salaries,

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[1] Excerpts from Suicide Prevention in the Schools: Guidelines for Middle and High School Settings by David Capuzzi, Copyright © 1994 by the American Counseling Association in Alexandria Virginia.

less time may be available for parenting roles. Traditional values may seen questionable and increasing emphasis on education, which lengthens preparation time for jobs or careers which may not provide the quality of life enjoyed by today's adults, may make it even harder for adolescents to develop needed perspective. For some adolescents the use and abuse of alcohol and other substances, running away, dropping out of school, developing eating disorders, sexual acting out, and other at-risk behaviors may be connected with the need to lower stress and may be preludes to increased vulnerability for a suicide attempt or completion.

Family Dysfunctions

Divorce, death, unemployment, moving, etc. are frequent occurrences in American families which must be dealt with in a way that promotes problem solving and good communication. Individuals in functional family systems can usually make the adjustments necessary to cope constructively with changes in the family. Members of dysfunctional families, however, usually experience high stress during periods of transition.

There are a number of patterns that can be observed in dysfunctional families which can impact an adolescent's vulnerability to depression and suicidal preoccupation (Capuzzi, 1986).

Poor communication skills. In most families of adolescents who have attempted or completed suicide, communication between parents or between parents and children (and usually both) has not been optimal. Family members may have difficulty describing their thoughts and their feelings or be uneasy about sharing them even if they are able

to articulate accurately. Parents may have been taught to suppress self-expression or may have been subjected to bursts of anger with little explanation or description provided. Children and adolescents usually do not attain communication levels higher than those of their parents. They may be unable or afraid to express themselves and parents may have little awareness of the tribulations experienced by an adolescent son or daughter.

Resistance to the grieving process. Loss is something that requires a grieving and adjustment process which passes through a series of phases or stages. The dissolution of the family of origin because of death or a divorce, changes in health status or job security, or moves to new housing or a new community require major psychological adjustments and changed perspectives. Quite often, suicidal adolescents come from families which have experienced losses and in which individual family members have resisted the need to grieve and denied the range of feelings which accompany the grieving process.

Difficulties with single parenting. The role of the single parent in American society is difficult. Escalating responsibility, lowered income, high stress, and lack of time are only a few examples of the kinds of problems a single parent may encounter. It is difficult for even the most functional of adults to cope with the parameters of raising a child (or children) without the emotional support and financial assistance a partner can provide.

Confusion in a blended family. When two adults who have custody of the children from a previous marriage decide to form a new family, the dynamics of the family

constellation can become quite complex. For some adolescents, it is too difficult to adjust to a "substitute" parent for the one lost through a divorce, a new set of guidelines for behavior and discipline, additional siblings, less personal space, or a different home in a new neighborhood or community.

Mid-life transition stressors. Adolescence, particularly early adolescence, is a time of rapid psychological and physical change. Many parents do not realize that their adolescent children are being called upon to cope with changes that are as numerous and as rapid as the changes they experienced during the first year of life. They do not realize that they need to spend as much or more time with their children than ever before because adolescent children look more like young adults than children in need of support, structure, and guidelines. Since parents of adolescents are usually between the ages of 35 and 50, they may be focused on assessing themselves as personalities, as partners, as career achievers, and as income providers. Often such parents, particularly parents whose own dysfunctions inhibit their perspective and their parenting abilities, fail to understand the needs of their adolescent children and do not provide the time and the structure and stability so necessary for optimal family functioning.

Abusive interactions. Families in which physical or sexual abuse is occurring or in which substance abuse is problematic may be at high risk for adolescent suicide. Parents who are abusive of each other, themselves, or their children are typically low in self-esteem, stressed, poor communicators and problem-solvers and financially distressed. Children of such parents have not been taught to feel good about themselves and to problem-solve well. During adolescence, escaping the pain of such a family

atmosphere or the self-depreciating viewpoint they have probably developed may become the most predominating motivation for suicide.

Environmental Pressures

Academic achievement. Schools and families often pressure their adolescent students/children to emphasize scholarly pursuits at the expense of developing relationships, hobbies, and pastimes which provide enjoyment and balance to release stresses and renew energy. Even good students can be the recipients of pressure, threats, and admonitions to achieve spiraling levels of achievement and excellence. When an adolescent whose identity is too aligned with school related pursuits develops anxiety over the need for continued performance, he/she may become preoccupied with suicide as a means to escape increasing pressures.

Constant mobility. Although a reasonable amount of change and mobility can be renewing and energizing, too much mobility can provide the basis for isolation, loneliness, and alienation. Often mobility is mandated because of career opportunities, divorce, or a desire to improve upon environmental circumstances. Unfortunately, too much movement can result in depression and exhaustion.

High school completion. Even though many adolescents register emphatic complaints about the requirements connected with progression through and graduation from secondary education and "proclaim" the joys of high school completion, most adolescents experience a great deal of stress about the future. Suddenly, they will no longer be with peers they may have seen daily for years; the post high school environment may be completely new and lack the "structure" provided by secondary

schools. Adolescents already at risk for suicide may be even more vulnerable prior to and after graduation because their stress levels may further impair decision making, coping, and adjustment relative to the myriad of changes and transitions they will experience.

Availability of drugs. Most fifth and sixth graders in the United States can access the use of illicit drugs. Opportunities to experiment with alcohol, marijuana, and other drugs are common and often young people are pressured by their peers to participate and threatened with expulsion from the group if they refuse. Many vulnerable upper elementary and early adolescents mistake or confuse their involvement with the drug culture as something which can enhance their feelings of well being and autonomy. Since problem solving ability, self-esteem, communication skills, etc., which may already be inadequate, are never enhanced through the use of drugs, suicide prone adolescents usually increase their risks as drug experimentation and dependency increase.

ADOLESCENT SUICIDE PREVENTION:

WHAT YOU NEED TO KNOW

The most effective tool in preventing suicide is knowledge. Since 90% of the adolescent suicide attempters warn us of their plans, it is imperative that everyone recognizes the signs and knows what to do about them.

Understanding The Myths

It is important to disqualify myths and misconceptions surrounding the topic of

adolescent suicide at the beginning of any initiative to provide prevention, crisis management and postvention services. Some of the most commonly cited misconceptions include the following (Capuzzi, 1988):

1. **Adolescents who talk about suicide never attempt suicide.** This is probably one of the most widely believed myths. All suicidal adolescents make attempts (either verbally or nonverbally) to let a friend, parent, or teacher know that life seems to be too difficult to bear. Since a suicide attempt is a cry for help to identify options other than death and to decrease the pain of living, always take verbal threats seriously. Never assume such threats are only for the purpose of attracting attention or manipulating others. It is better to respond and enlist the aid of a professional than to risk the loss of a life.

2. **Suicide happens with no warning.** Suicidal adolescents leave numerous hints and warnings about their suicidal ideations and intentions. Clues can be verbal or in the form of suicidal gestures such as taking a few sleeping pills, becoming accident prone, reading stories focused on death and violence, etc. Quite often, the social support network of the suicidal adolescent is small. As stress escalates and options, other than suicide, seem few, suicidal adolescents may withdraw from an already small circle of friends making it more difficult for others to notice warning signs.

3. **Adolescents from affluent families attempt or complete suicide more often than adolescents from poor families.** This, too, is a myth. Suicide is evenly divided among socioeconomic groups.

4. **Once an adolescent is suicidal, he or she is suicidal forever.** Most

adolescents are suicidal for a limited period of time. In the experience of the author, the 24-72 hour period around the peak of the "crisis" is the most dangerous. If counselors and other mental health professionals can monitor such a crisis period and transition the adolescent into long-term counseling/therapy, there is a strong possibility there will never be another suicidal crisis. The more effort that is made to help an adolescent identify stressors and develop problem-solving skills during this post-suicidal crisis period and the more time that passes, the better the prognosis.

5. **If an adolescent attempts suicide and survives, he or she will never make an additional attempt.** There is a difference between an adolescent who experiences a suicidal crisis but does not attempt suicide, as in the example above, and the adolescent who actually makes an attempt. An adolescent who carries through with an attempt has identified a plan, had access to the means and maintained a high enough energy level to follow through. He or she may believe that a second or third attempt may be possible. If counseling/therapy has not taken place or has not been successful during the period following an attempt, additional attempts may be made. Most likely, each follow-up attempt will become more lethal.

6. **Adolescents who attempt or complete suicide always leave notes.** Only a small percentage of suicidal adolescents leave notes. This is a common myth and one of the reasons why many deaths are classified and reported as accidents by friends, family members, physicians and investigating officers when suicide has actually taken place.

7. **Most adolescent suicides happen late at night or during the predawn**

hours. This myth is not true for the simple reason that most suicidal adolescents actually want help. Mid to late morning and mid to late afternoon are the time periods when most attempts are made since a family member or friend is more likely to be around to intervene than would be the case late at night or very early in the morning.

8. **Never use the word suicide when talking to adolescents because using the word gives some adolescents the idea.** This is simply not true; you cannot put the idea of suicide into the mind of an adolescent who is not suicidal. If an adolescent is suicidal and you use the word, it can help an adolescent verbalize feelings of despair and assist with establishing rapport and trust. If a suicidal adolescent thinks you know he or she is suicidal and realizes you are afraid to approach the subject, it can bring the adolescent closer to the point of making an attempt by contributing to feelings of despair and helplessness.

9. **Every adolescent who attempts suicide is depressed.** Depression is a common component of the profile of a suicidal adolescent but depression is not always a component. Many adolescents simply want to escape their present set of circumstances and do not have the problem-solving skills to cope more effectively, lower stress, and work towards a more promising future.

10. **Suicide is hereditary.** Suicide tends to run in families similar to physical and sexual abuse. This fact has led to the development of the myth. Suicide is not genetically inherited. Members of families do, however, share the same emotional climate since parents model coping and stress management skills as well as a level of high or low self-esteem. The suicide of one family member tends to increase the risk among

other family members that suicide will be viewed as an appropriate way to solve a problem or set of problems.

In conjunction with this myth, it should be noted that endogenous depression can be inherited. Because of the connection between depression and suicide, many have mistakenly come to the belief that suicide can be genetically inherited.

Recognizing the Profile

One of the essential components of any staff development effort is teaching the profile of the suicidal or potentially suicidal adolescent so that referral and intervention can take place. Behavioral, verbal and cognitive cues and personality traits are the four areas which will be described below.

Behaviors

Lack of concern about personal welfare. Some adolescents who are suicidal may not be able to talk about their problems or give verbal hints that they are at risk for attempting suicide. Sometimes such adolescents become unconcerned with their personal safety in the hopes that someone will take notice. Experimenting with medication, accepting "dares" from friends, reckless driving, carving initials into the skin of forearms, etc. may all be ways of "gesturing" or letting others know, "I am in pain and don't know how to continue through life if nothing changes."

Changes in social patterns. Relatively unusual or sudden changes in an adolescent's social behavior can provide strong cues that such a young person is feeling desperate. A cooperative teenager may suddenly start breaking the "house rules" which parents have never had to worry about enforcing. An involved adolescent may begin to

withdraw from activities at school or end long-term friendships with school and community related peers. A stable, easy-going teenager may start arguing with teachers, employers or other significant adults with whom prior conflict was never experienced.

A decline in school achievement. Many times, adolescents who are becoming more and more depressed and preoccupied with suicidal thoughts are unable to devote the time required to complete homework assignments and maintain grades. If such an adolescent has a history of interest in the school experience and has maintained a certain grade point average, loss of interest in academic pursuits can be a strong indication that something is wrong. The key to assessing such a situation is the length of time the decline lasts.

Concentration and clear thinking difficulties. Suicidal adolescents usually experience marked changes in thinking and logic. As stress and discomfort escalate, logical problem solving and option generation becomes more difficult. As reasoning and thinking become more confused and convoluted, it becomes easier and easier to stay focused on suicide as the only solution.

Altered patterns of eating and sleeping. Sudden increases or decreases in appetite and weight, difficulty with sleeping or wanting to sleep all the time or all day can all be indicative of increasing preoccupation with suicidal thoughts.

Attempts to put personal affairs in order or to make amends. Often, once a suicide plan and decision have been reached, adolescents will make "last minute" efforts to put their personal affairs in order. These efforts may take a variety of directions: attempts to make amends in relation to a troubled relationship; final touches on a project,

reinstatement of an old or neglected friendship, the giving away of prized possessions.

Use or abuse of alcohol or drugs. Sometimes troubled adolescents use or abuse alcohol or other drugs to lessen their feelings of despair or discontent. Initially, they may feel that the "drug" enhances their ability to cope and to increase feelings of self-esteem. Unfortunately, the abuse of drugs decreases ability to communicate accurately and problem solve rationally. Thinking patterns become more skewed, impulse control lessens and option identification decreases.

Unusual interest in how others are feeling. Suicidal adolescents often express considerable interest in how others are feeling. Since they are in pain, but may be unable to express their feelings and ask for help, they may reach out to peers (or adults) who seem to need help with the stresses of daily living.

Preoccupation with death and violence themes. Reading books or poetry in which death, violence or suicide is the predominating theme can become the major interest of an adolescent who is becoming increasingly preoccupied with the possibility of suicide. Other examples of such preoccupation can include listening to music which is violent; writing short stories focused on death, dying and loss; drawing or sketching which emphasizes destruction; or watching movies which emphasize destruction of self and others.

Sudden improvement after a period of depression. Suicidal adolescents often fool parents, teachers, and friends by appearing to be dramatically improved, in a very short period of time, after a period of prolonged depression. This improvement can sometimes take place overnight or during a 24 hour period and encourages friends and family who

interpret such a change as a positive sign. It is not unusual for a change, such as the one described above, to be the result of a suicide decision and the formulation of a concrete suicide plan on the part of the adolescent at risk. It may mean that the suicide attempt (and the potential of completion) is imminent and that the danger and crisis is peaking.

Sudden or increased promiscuity. It is not unusual for an adolescent to experiment with sex during periods of suicidal preoccupation in an attempt to refocus attention or lessen feelings of isolation. Unfortunately, doing so sometimes complicates circumstances because of an unplanned pregnancy or an escalation of feelings of guilt.

Verbal Cues

There is no "universal" language or "style" for communicating suicidal intention. Some adolescents will openly and directly say something like "I am going to commit suicide" or "I am thinking of taking my life." Others will be far less direct and make statements such as: "I'm going home," "I wonder what death is like," "I'm tired," "She'll be sorry for how she has treated me" or "Someday I'll show everyone just how serious I am about some of the things I've said."

The important thing for counselors, parents, teachers, and friends to remember is that, when someone says something that could be interpreted in a number of ways, it is always best to ask for clarification.

Thinking Patterns and Motivations

Often suicidal adolescents distort their thinking patterns in conjunction with the three functions of avoidance, control and communication so that suicide becomes the best

or only problem solving option. Such distortions can take a number of directions. All-or-nothing thinking, for example, can enable an adolescent to view a situation in such a polarized way that the only two options seem to be continuing to be miserable and depressed or carrying out a suicide plan; no problem solving options to cope with or overcome problems may seem possible (Capuzzi, 1988). Identification of a single event which is then applied to all events is another cognitive distortion, that of over-generalization. Such distortions result in self-talk which becomes more and more negative and more and more supportive of one of the following motivations for carrying through with a suicide plan:

- Wanting to escape from a situation which seems (or is) intolerable (e.g., sexual abuse, conflict with peers or teachers, pregnancy, etc.).
- Wanting to join someone who has died.
- Wanting to attract the attention of family or friends.
- Wanting to manipulate someone else.
- Wanting to avoid punishment.
- Wanting to be punished.
- Wanting to control when or how death will occur (an adolescent with a chronic or terminal illness may be motivated in this way).
- Wanting to end a conflict that seems unresolvable.
- Wanting to punish the survivors.
- Wanting revenge.

Personality Traits

Although no consensus has yet been reached on the "usual," "typical," or

"average" constellation of personality traits of the suicidal adolescent, researchers have agreed on a number of characteristics which seem to be common to many suicidal adolescents.

Low self-esteem. The counseling experience of the author as well as the experience of other practitioners seems to substantiate the relationship between low self-esteem and suicide probability. Almost all such clients have issues focused on feelings of low self-worth and almost all such adolescents have experienced these self-doubts for an extended time period.

Hopelessness/helplessness. Most suicidal adolescents report feeling hopeless and helpless in relation to their circumstances as well as their ability to cope with these circumstances. Most practitioners can expect to address this issue with suicidal clients and to identify a long-term history of feeling hopeless and helpless on the part of most clients.

Isolation. Many, if not most, suicidal adolescents tend to develop a small network of social support. They may find it uncomfortable to make new friends and rely on a small number of friends for support and companionship.

High stress. High stress coupled with poor stress management skills seems to be characteristic of the suicidal adolescent.

Acting out. Behaviors such as truancy, running away, refusal to cooperate at home or at school, use or abuse of alcohol or other drugs, experimentation with sex, etc. are frequently part of the pattern present in the life of a suicidal adolescent.

Need to achieve. Sometimes, adolescents who are suicidal exhibit a pattern of

high achievement. This achievement may be focused on getting high grades, being the "class clown," accepting the most "dares," wearing the best clothes, or any one of numerous other possibilities. In the counseling experience of the writer, this emphasis on achievement often is a compensation for feelings of low self-esteem.

Poor communication skills. Suicidal adolescents often have a history of experiencing difficulty with expression of thoughts and feelings. Such adolescents may have trouble with identifying and labeling what they are feeling; self-expression seems awkward if not stressful.

Other directedness. Most suicidal adolescents are "other" rather than "inner" directed. They are what others have told them they are instead of what they want to be; they value what others have said they "should" instead of what they deem to be of personal value and worth.

Guilt. Usually connected with feelings of low self-esteem and a need to be other directed, the guilt experienced by many suicidal adolescents is bothersome and sometimes linked to a "wanting to be punished" motivation for suicide.

Depression. Depression is a major element in the total profile of the suicidal adolescent. Hafen and Frandsen (1986) pointed out that there are sometimes differences between depression in an adult and depression in an adolescent. Adults are often despondent, tearful, sad, or incapable of functioning as usual. Although adolescents sometimes exhibit these characteristics, they may also respond with anger, rebelliousness, truancy, running away, using and abusing drugs, etc. Considering the complexity of the environment that adolescents must confront, it is normal to experience

some short-term depression. But when depression becomes more frequent and more intense, to the point that the adolescent has trouble functioning at school or at home, it may be a forewarning of more serious problems.

How You Can Help

If you have concerns about an adolescent, your role is to express your concern, develop rapport, and facilitate a meeting with a counselor or crisis team member. This meeting should take place as quickly as possible. Most adolescents attempt suicide 24 to 72 hours after the peak period of their suicidal preoccupation.

The following guidelines may be helpful to you in the process of getting an adolescent to someone who can make an assessment and decide on what needs to be done.

Step 1

Assess the suicidal risk factors utilizing what you know about the "profile" of a suicidal adolescent. Do not be afraid to ask directly if the person has entertained thoughts of suicide. Experience shows that harm is rarely done by inquiring into such thoughts at an appropriate time. In fact, the suicidal individual often welcomes the query and the opportunity to open up and discuss it. Remember, the more detailed an individual's thoughts and plans, the more serious the suicidal possibility. However, all suicidal thoughts should be taken seriously.

Step 2

Listen and paraphrase. The most important thing for a person in distress is someone who will listen and really hear what is being said. Paraphrase what you think

you are hearing.

Step 3

Evaluate the seriousness of the young person's situation.

It is possible for an adolescent to be extremely upset but not suicidal or to appear mildly upset and yet be suicidal. Try to understand the situation and circumstances and the meaning attached to these by the individual you are concerned about.

Step 4

Take every complaint and feeling the person expresses seriously. Do not dismiss or discount the person's concerns. Let the person know that you understand their perspective but that you may also be able to see things in another way.

Step 5

Begin to broaden the person's perspective of his/her past and present situation. Point out that depression often causes people to see only some things (the negatives) and to be temporarily unable to see other things (the positives). Elicit positive aspects of the person's past and present which are being ignored but which could be regained.

Step 6

Be positive in your outlook of the future. Let the adolescent know that predictions of a hopeless future are only guesses, not facts. Contrast the finality of death with the uncertainty which the future holds. Speculate on how the person's life would be different if just one or two changes could be made but do not attempt to argue or convince.

Step 7

Evaluate available resources. Help the person to identify and mobilize resources that can lend support during the crisis. Suicidal persons often withdraw from available support just when they need it most. Let the person know that you will help in any way that you can and that others can help also. Strong, stable supports are essential in the life of a distressed individual.

Step 8

Call upon another professional. Call upon whomever is needed depending upon the severity of the situation. Do not try to handle everything alone. Convey an attitude of firmness and self-assurance so that the person will feel that you know what you are doing and that whatever is necessary and appropriate will be done to help.

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