What Parents and Teachers should Know about Suicide in Adolescents (Part 1)

By Dr. Shahul Ameen, M.D. INTRODUCTION Suicide is one of the commonest causes of death among young people. The latest mean worldwide annual rates of suicide per 100,000 are 0.5 for females and 0.9 for males among 5-14-year-olds, and 12.0 for females and 14.2 for males among 15-24-year-olds. Suicide is the sixth leading cause of death among children aged 5-14 years, and the third leading cause of death among all those 15-24 years old. In most countries, males outnumber females in youth suicide statistics. There are far more suicidal attempts and gestures than actual completed suicides. One epidemiological study estimated that there were 23 suicidal gestures and attempts for every completed suicide. Though female teens are much more likely to attempt suicide than males, male teens are more likely to actually kill themselves. The suicide rate among young teens and young adults has increased by more than 300% in the last three decades. Social changes that might be related to the rise in adolescent suicide include an increased incidence of childhood depression and decreased family stability. Some researchers argue that economic and political institutions have penetrated the family unit, reducing it to a consumer unit no longer able to function as a support system, and no longer able to supply family members with a sense of stability and rootedness. Awareness of the existing state of the world, now threatened by sophisticated methods of destruction, can cause depression which contributes to the adolescent's sense of frustration, helplessness, and hopelessness. Faced with these feelings and lacking coping mechanisms, adolescents can become overwhelmed and turn to escapist measures such as drugs, withdrawal, and ultimately suicide. The rising rate has also been explained as a reaction to the stress inherent in adolescence compounded by increasing stress in the environment. Adolescence is a time when ordinary levels of stress are heightened by physical, psychological, emotional, and social changes. Adolescents suffer a feeling of loss for the childhood they must leave behind, and undergo an arduous period of adjustment to their new adult identity. Yet society alienates adolescents from their new identity by not allowing them the rights and responsibilities of adulthood. They are no longer children, but they are not accorded the adult privileges of expressing their sexuality or holding a place in the work force. Our achievement-oriented, highly competitive society puts pressure on the teens to succeed, often forcing them to set unrealistically high personal expectations. There is increased pressure to stay in school, where success is narrowly defined and difficult to achieve. In an affluent society which emphasizes immediate rewards, adolescents are not taught to be tolerant of frustration. RISK FACTORS FOR SUICIDE Contrary to popular belief, suicide is not an impulsive act but the result of a three-step process: a previous history of problems is compounded by problems associated with adolescence; finally, a precipitating event, often a death or the end of a meaningful relationship, triggers the suicide. The major, empirically proven risk actors for suicide among adolescents are detailed below. PERSONAL CHARACTERISTICS Psychopathology: More than 90% of youth suicides and around 60% of younger adolescent suicide victims have had at least one major psychiatric disorder. The most prevalent disorder in adolescent suicide victims is depressive disorders. Depression that seems to quickly disappear for no apparent reason is a cause for concern, and the early stages of recovery from depression can be a high risk period. Substance abuse, conduct disorder, posttraumatic stress disorder and panic attacks are the other disorders found to be common in this population. Previous suicide attempts: A history of prior suicide attempts is one of the strongest predictors of completed suicide, especially in boys. One quarter to one third of teen suicide victims have made a previous suicide attempt. Cognitive and personality factors: Hopelessness, poor interpersonal problem solving ability and aggressive impulsive behaviour have been linked with suicidality. Biological factors: Some teens are at greater risk for suicide because of their biochemical makeup. Abnormalities in the function of serotonin, a neurotransmitter, have been associated with suicidal behaviour. FAMILY CHARACTERISTICS Family history of suicidal behaviour: Teens who kill themselves have often had a close family member who attempted or committed suicide. Parental psychopathology: High rates of parental psychopathology, particularly depression and substance abuse, have been found to be associated with completed suicide and suicidal ideation and attempts in adolescents. Moreover, family cohesion has been reported to be a protective factor for suicidal behaviour among adolescents. ADVERSE LIFE CIRCUMSTANCES Stressful life events: Life stressors such as interpersonal losses and legal or disciplinary problems are associated with completed suicide and suicide attempts in adolescents. The anniversary of a loss can also evoke a powerful desire to commit suicide. Common problems preceding suicide attempts: * School or work problems
* Difficulties with boyfriends or girlfriends
* Physical ill health
* Difficulties or disputes with parents, siblings or peers
* Depression
* Bullying
* Low self esteem
* Sexual problems Physical abuse: Childhood physical abuse has been found to be associated with increased risk of suicide attempts in late adolescence and early adulthood. SOCIOECONOMIC AND CONTEXTUAL FACTORS School and work problems: Difficulties in school, neither working nor being in school, dropping out of high school and not attending college pose significant risks for completed suicide. Contagion/Imitation: Teens are more likely to kill themselves if they have recently read, seen, or heard about other suicide attempts. Evidence continues to amass from studies of suicide clusters and the impact of the media, supporting the existence of suicide contagion. The impact of suicide stories on subsequent competed suicides appears to be greatest for teenagers. PREVENTION STRATEGIES Youth suicide prevention strategies have primarily been implemented within three domains -

school, community, and health are systems. This article reviews the school-based programs in detail and briefly describes the community based interventions. SCHOOL-BASED SUICIDE PREVENTION PROGRAMS School based suicide prevention programs include both curricula components to teach students about these warning signs and what to do, as well as non-curricula components such as peer groups, hot lines, intervention services and parent training. Prevention includes education efforts to alert students and the community to the problem of teen suicidal behavior. Intervention with a suicidal student is aimed at protecting and helping the student who is currently in distress. Postvention occurs after there has been a suicide in the school community. It attempts to help those affected by the recent suicide. In all cases it is a good idea to have a clear plan in place in advance. It should involve staff members and administration. There should be clear protocols and clear lines of communication. Careful planning can make interventions more organized, and effective. The goals of school based suicide prevention programs are to: * Increase awareness
* Promote identification of students at high risk of suicide and suicide attempts
* Provide knowledge about the behavioral characteristics ("warning signs") of teens at risk for suicide.
* Provide information to students, teachers and parents on the availability of mental health resources
* Enhance the coping abilities of teenagers Education: Education may be done in a health class, by the school counselor or outside speakers. Education should address the factors that make individuals more vulnerable to suicidal thoughts. Education regarding the ill effects of drug and alcohol abuse would be useful. PTA meetings can be used to educate parents about depression and suicidal behavior. Parents should be educated about the risk of unsecured firearms in the home. Outside mental health professionals can discuss their programs so that students can see that these individuals are approachable. Education on the following topics will be useful: Warning signs of suicide: * Preoccupation with death and dying
* Signs of depression
* Taking excessive risks
* Increased drug use
* The verbalizing of suicide threats
* The giving away of prized personal possessions
* The collection and discussion of information on suicide methods
* The expression of hopelessness, helplessness, and anger at oneself or the world
* Themes of death or depression evident in conversation, written expressions, reading selections, or artwork
* The scratching or marking of the body, or other self-destructive acts
* Acute personality changes, unusual withdrawal, aggressiveness, or moodiness
* Sudden dramatic decline or improvement in academic performance, chronic truancy or tardiness, or running away
* Physical symptoms such as eating disturbances, sleeplessness or excessive sleeping, chronic headaches or stomachaches, menstrual irregularities, apathetic appearance Sudden changes in behavior that are significant, last for a long time, and are apparent in all or most areas of his or her life (pervasive) are more specific than presence of isolated signs. However, it should be noted that many completed suicides had only a few of the conditions listed above, and that all indications of suicidality need to be taken seriously in a one person to another person situation. Signs of depression in teens: * Sad, anxious or "empty" mood
* Declining school performance
* Loss of pleasure/interest in social and sports activities
* Sleeping too much or too little
* Changes in weight or appetite Features of self harm that suggest high suicidal intent: * Conducted in isolation
* Timed so that intervention is unlikely (for example, after parents have gone to work)
* Precautions to avoid discovery
* Preparations made in anticipation of death (for example, leaving indication of how belongings to be distributed)
* Adolescent told other people beforehand about thoughts of suicide
* The act had been considered for hours or days beforehand
* Suicide note or message
* Adolescent did not alert others during or after the act (Article continued in Part II)

About the Author

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