Suicidal Tendencies in Adolescents

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Adolescent suicide has become an issue of increasing concern over the past twenty-five years within Australia and other western countries. Epidemiological studies have demonstrated a significant rise in suicidal behaviour among adolescents, to the extent that suicide is presently the second leading cause of death for the 15-19 year old age group (Berman &Jobes, 1995: Hazell, 1991) with the rate of completed suicide showing an increase of over 300% since the 1 *950s* (Leane& Shute, 1998: Lewis & Lewis, 1996). Approximately 500 adolescents complete suicide each year (Cantor, *1995;* Mallet &Swabey, 1997). These official statistics are considered to be an underestimate of the true incidence of suicidal behaviour due to the public stigma and cultural taboos associated with suicide, and related methodological flaws in the classification of cause of death (Garland &Zigler, 1993).

Suicide attempts are even mare prevalent than completions, with estimates ranging between 50 to 200 attempts far every actual suicide (Orbach& Bar-Joseph, 1993: Steele & McLennan, 1995). Culp, Clyman and Culp *(1995)* surveyed a sample of high school students and found 6% had attempted suicide, while 33% had reported some degree of suicide ideation. Similar results have been obtained by Eskin (1992), indicating that suicidal behaviour is indeed highly prevalent within the adolescent population.

Suicide Prevention Efforts

Given the alarming increase in suicide reported behaviours, preventing youth suicide has become an issue of paramount importance in recent years (Leane& Shute, 1998) with the focus on primary prevention. In relation to suicide this may involve providing life skills training, improving social support, and educating adolescents about self-destructive urges and treatment options (Leenaars&Wenckstern, 1998).

In the USA, suicide prevention programs have been in operation since the late 1970s, primarily through the secondary school system (Berman &Jobes, 1995) with many states having introduced legislation requiring and supporting school-based suicide prevention programs (Sandoval, London & Rey, 1994). However, no such requirement regarding mandatory suicide curriculum in secondary schools currently exists within Australia (Cantor, 1995).

Given these findings it is imperative that adolescents are aware of the appropriate responses to suicidal individuals, however, research indicates this does not seem to be the case. Mishara (1982) reported that over 90% of an adolescent sample indicated having had contact with a fellow student who expressed suicidal feelings. Of this sample, 40% joked about the suicidal intent or ignored the suicidal peer, hence, demonstrating that a substantial proportion of adolescents appear to be unaware of the appropriate response to suicidal behaviour.

Wellman and Wellman (1986) suggested that because suicide is a topic that frequently provokes anxiety, joking about the feared stimulus (suicide intent) is a method of coping with such feelings. Anxiety about suicide may be attributed to a lack of knowledge regarding the topic as well as assimilation of the traditional social taboo surrounding this issue. Furthermore, peer confidants are unlikely to approach an adult for assistance in helping a suicidal peer. This reluctance may be due to growing autonomy from adults, the importance of keeping the confidences of peers and misgivings about adult helpers (Kalafat& Elias. 1992). Regardless of the reason, it is imperative that adolescents are educated to recognise potential warning signs indicating suicidal behaviour, and are *5* competent in accessing professional assistance for troubled peers. Peer confidants have the potential to play a fundamental role in preventing suicidal adolescents from progressing to completed suicide given the appropriate education (Kalafat& Elias, 1995).

Obstacles to School-Based Suicide Prevention

While the implementation of suicide awareness programs within schools appears to have an identifiable rationale, the reluctance of schools to address the issue or suicide cannot be ignored. A number or objections have been raised about the adoption or suicide awareness curriculum with concerns having been expressed about the accuracy of the information disseminated. Descriptive studies on adolescent

suicide are still being undertaken, thus the warning signs and risk profiles or potential victims may not be based on accurate or representative findings (Shaffer, Garland, Vieland, Underwood, &Busner, 1991). Another concern is that the programs tend to adopt a 'universalist' approach in that, they target an unselected group or adolescents, the majority of who are not at nsk, instead of high-risk groups or adolescents (Shaffer **et** al., 1991). Research has suggested that only a minority of students hold views requiring intervention, and fewer still have any significant risk of suicidal behaviour, thus challenging the feasibility of primary prevention strategies (Hazell & King. 1996). Some schools appear to be under the misapprehension that adolescents may be susceptible to imitative suicidal behaviour, thus concerns exist that an educational approach may inadvertently facilitate and stimulate the expression of suicidal intent in vulnerable students (Kalafat, 199o). However, there appears to be limited support for this contagion hypothesis, with research indicating that discussion actually appears to facilitate openness on the part of the suicidal person, leading to intervention (Brent et al., 1992; Leenaars&Wenckstern, 1990).

Evaluations of School-Based Suicide Prevention

Limited studies have been conducted to systematically evaluate the effectiveness of school-based suicide awareness education and those that have have yielded controversial findings in terms of improvements in students attitudes towards and knowledge or adolescent suicide. Garland, Shaffer, and whittle (1989) conducted a

systematic evaluation of school-based suicide awareness programs and concluded that 6 prevention programs were ineffective, and may even have an unintended negative effect, especially on high-risk students. It was reported that youth with histories of prior suicide attempts endorsed more negative attitudes and beliefs about suicide and expressed increasingly negative responses to school wide suicide prevention programs than their peers who had never attempted suicide. In addition, males who were exposed to such programs were more likely to endorse suicide as a reasonable solution, in comparison to males not exposed to prevention programs.

Suicide Statistics

The statistics tell a grim story. For children 10 to 14, one per 100,0oo young people died by suicide, for adolescents 1s to 19, eight per 100,000 died by suicide, and for young adults 20 to 24, twelve out of 1o0,0o0 took their own life. children as young as five years old have committed suicide, and for every completed act or suicide there are over 100 attempts.

Unfortunately, adolescents also mimicked their elders in this behavior. Guns. suffocation, and poisoning were the...main methods for committing suicide, with suffocation being the method most used by children. Suicide is far more common with males. For those aged 15 to 19, four times the number of boys committed suicide compared to girls. For those aged 20 to 24, six times as many boys chose suicide compared to girls.

Suicide Risk Factors

Mood disorders such as depression, bipolar disorder, and severe anxiety disorders along with an alcohol or substance abuse disorder are the biggest risk factors for suicide. According to the office of the US. Surgeon General, over 90% of children and young adults who commit suicide have a mental illness.

The top two most. important risk factors for suicide for girls is major depression and a previous suicide attempt For boys, the top risk factor Is a previous suicide attempt, followed by depression, disruptive behavior, and substance abuse.

There are several warning signs that someone may be at increased risk of suicide, and they are:

Suicide notes — these should always be taken seriously

- Threatening suicide .direct or indirect
- Previous attempts or suicide
- Depression, particularly in 1he presence of thoughts of helplessness and hopelessness
- Risk-taking behavior, particularly anything involving gun play, aggression, or substance abuse
- Making final arrangements — this might involve giving away prized possess ions
- Efforts to hurt themselves, such as self-mutilating behavior and self-destructive acts
- Inability to concentrate or think rationally
- Changes in physical habits and appearance, such as-insomnia or hypersomnia (sleeping far too much), sudden weight gain or loss, disinterest in basic hygiene
- Great interest in death and suicidal themes — it might manifest in their journal, school papers, drawings

- Sudden changes in friends, personality and behavior, or withdrawal from family and friends
- Increased interest in things dealing with suicide — a sudden interest in guns or other weapons, pills, or even alluding to suicidal plans
- Vulnerable teens and young adults swayed by media reports of celebrity suicides, or the romanticized representation or suicide in movies and television
- Low levels of communication between parent and child .family discord has not been decisively shown to be a major risk factor for suicide, but it further exacerbates other problems such as depression, alcohol and drubs abuse
- Being bullied or victimized or being a bully

Unfortunately, many family and friends are left completely bewildered and shocked by the suicide of a young person. It Is not uncommon for families to never learn what brought someone to take their own life.

Parents, caregivers. and teachers are the best observers of an adolescent's behavior, and the best judges of suicidal tendencies in children and young adults. If you notice any of the above risk factors, notify your physician, the school counselor, or take them to see a mental health professional immediately. Don't dismiss your instincts or their feelings. If you think something is wrong, it Probably is.

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