

Suicide Among the Young: Facts and Preventative Steps

Objectives:

1. Participants will learn some common characteristics of American Indian youth who attempt suicide.
2. Participants will better understand how to help a young person who is contemplating suicide.
3. Participants will be more familiar with the types of resources that young people need when they are considering suicide.
4. Participants will learn the signs, symptoms and warnings of a young person considering suicide.
5. Participants will learn how to help parents and teachers recognize the warning signs of a suicidal youth.

Activities:

1. Discuss resources available to youth in our community who are considering suicide. Are there resources for the whole family or just the child/parent/caregiver? Are these resources culturally appropriate? If not, how do we find appropriate resources for families?
2. Develop a flow chart depicting the activities of the Child Protection Team when confronted with a possible youth suicide. Who is called first, what happens then, what resources are utilized, etc.

Discussion Questions:

1. Discuss the resources available in your community for youth who consider suicide. What do you do when a child mentions to you that they want to commit suicide? Who do you call? What do you tell them?
2. Discuss ways that you can better prepare parents and teachers to recognize the warning signs of suicide in youth. How can we help them develop strategies and activities to educate the community on youth suicide.
3. What can the Child Protection Team do to implement suicide prevention efforts in the schools, i.e., posters, pamphlets, speakers, etc.

Training Modules (Power Point Presentations):

Suicide Among Teens

Suicide Prevention Tips and Facts

Facts

The American Indian most inclined toward a completed suicide has the following social characteristics:

- He is often a male between 15 and 24 years of age.
- He is single.
- He is under the influence of alcohol just before his suicide attempt.
- He has lived with a number of ineffective or inappropriate parental substitutes because of familial disruption.
- He has spent time in boarding schools and has been moved from one to another.
- He has been raised by caretakers who have come into conflict with the law.
- He has often been jailed at an early age.
- He has experienced an emotional loss, such as divorce, desertion, or death in the family.
- He has experienced a past loss through violence of someone to whom he felt attached.

10 Preventive Steps

- 1. Listen.** The first thing a patient in a mental crisis needs is someone who will listen and really know what he is saying. Every effort should be made to really understand the feelings behind the words.
- 2. Evaluate the seriousness of the suicidal patient's feelings.** All suicidal talk should be taken seriously. If the patient has made definite plans, the problem is apt to be more acute than when his thinking is less definite.
- 3. Evaluate the intensity or severity of the emotional disturbance.** It is possible that the patient may be extremely upset but not suicidal. If a person has been depressed and then becomes agitated and moves about restlessly, it is cause for alarm.
- 4. Take every complaint and feeling the patient expresses seriously.** Do not dismiss or undervalue what the person is saying. In some instances the person may express his difficulty in a low-key manner.
- 5. Do not be afraid to ask directly if the person has entertained thoughts of suicide.** Suicide may be suggested but not specifically mentioned in the crisis period. Experience shows that harm is rarely done by inquiring directly into the person's thoughts. In fact, the individual welcomes it and is glad the counselor enables him to open up and bring it out.
- 6. Do not be misled by the suicidal person's comments that he is alright and is past the crisis.** Often the suicidal person will feel initial relief after talking of suicide, but many times on second thought he will try to cover it up. The same thinking will come back later, however. Follow up is crucial to insure a good treatment program.
- 7. Be affirmative but supportive.** Strong, stable guideposts are extremely necessary in the life of a distressed individual. Provide him with strength by giving him the impression that you know what you are doing and that you intend to do everything possible to prevent him from taking his life.
- 8. Evaluate the resources available.** The person may have both inner psychological resources, such as various mechanisms for rationalization and intellectualization which

can be strengthened and supported, and other resources such as ministers, tribal elders, relatives and others whom one can call in. If these are absent, the problem is more serious. Careful observation and support are necessary.

9. Act specifically. Do something tangible; that is, give the patient something definite to hang onto, such as arranging for him to see someone else. Nothing is more frustrating to the patient than to leave the counselor's office and feel as though he received nothing from the interview.

10. Don't be afraid to ask for assistance and consultation. Call upon whomever is needed, depending upon the severity of the case. Don't try to handle everything alone. Convey an attitude of firmness and composure to the suicidal person so he will feel that something realistic and appropriate is being done to help.

(Source: American Indian and Alaskan Native Mental Health Research)

Suicide Among the Young

NOTE: Statistics are taken from the Centers for Disease Control and Prevention.

- Persons under age 25 accounted for 15% of all suicides in 1997. From 1952-1995, the incidence of suicide among adolescents and young adults nearly tripled. From 1980-1997, the rate of suicide among persons aged 15-19 years increased by 11% and among persons aged 10-14 years by 109%. From 1980-1996, the rate increased 105% for African American males aged 15-19.
- For young people 15-24 years old, suicide is the third leading cause of death, behind intentional injury and homicide. In 1997, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease **combined**.
- Among persons aged 15-19 years, firearm related suicides accounted for 62% of the increase in the overall rate of suicide from 1980-1997.
- The risk for suicide among young people is greatest among young males. Young American Indian and Alaska Native males have much higher rates of suicide than young White males. In 1999, the U.S. suicide rate for American Indian males ages 15-19 was 36.5 per 100,000 versus 13.9 per 100,000 for White males ages 15-19. (According to Todd Mosher Research Analyst, Alaska Bureau of Vital Statistics).
- Although suicide among young children is a rare event, the dramatic increase in the rate among persons aged 10-14 years underscores the urgent need for intensifying efforts to prevent suicide among persons in this age group.

Frequently Asked Questions About Suicide

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What should you do if someone tells you they are thinking about suicide?

If someone tells you they are thinking about suicide, you should take their distress seriously, listen nonjudgmentally, and help them get to a professional for evaluation and treatment. People consider suicide when they are hopeless and unable to see alternative solutions to problems. Suicidal behavior is most often related to a mental disorder (depression) or to alcohol or other substance abuse. Suicidal behavior is also more likely to occur when people experience stressful events (major losses, incarceration). If someone is in imminent danger of harming himself or herself, do not leave the person alone. You may need to take emergency steps to get help, such as calling 911. When someone is in a suicidal crisis, it is important to limit access to firearms or other lethal means of committing suicide.

What are the most common methods of suicide?

Firearms are the most commonly used method of suicide for men and women, accounting for 60 percent of all suicides. Nearly 80 percent of all firearm suicides are committed by white males. The second most common method for men is hanging; for women, the second most common method is poisoning including drug overdose. The presence of a firearm in the home has been found to be an independent, additional risk factor for suicide. Thus, when a family member or health care provider is faced with an individual at risk for suicide, they should make sure that firearms are removed from the home.

Why do men commit suicide more often than women do?

More than four times as many men as women die by suicide; but women attempt suicide more often during their lives than do men, and women report higher rates of depression. Several explanations have been offered: a) Completed suicide is associated with aggressive behavior that is more common in men, and which may in turn be related to some of the biological differences identified in suicidality, b) Men and women use different suicide methods. Women in all countries are more likely to ingest poisons than men. In countries where the poisons are highly lethal and/or where treatment resources are scarce, rescue is rare and hence female suicides outnumber males. More research is needed on the social-cultural factors that may protect women from completing suicide, and how to encourage men to recognize and seek treatment for their distress, instead of resorting to suicide.

Who is at highest risk for suicide in the U.S.?

There is a common perception that suicide rates are highest among the young. However, it is the elderly, particularly older white males that have the highest rates. And among white males 65 and older, risk goes up with age. White men 85 and older have a suicide rate that is six times that of the overall national rate. Why are rates so high for this group? White males are more deliberate in their suicide intentions; they use more lethal methods (firearms), and are less likely to talk about their plans. It may also be that older persons are less likely to survive attempts because they are less likely

to recuperate. Over 70 percent of older suicide victims have been to their primary care physician within the month of their death, many with a depressive illness that was not detected. This has led to research efforts to determine how to best improve physician's abilities to detect and treat depression in older adults.

Do school-based suicide awareness programs prevent youth suicide?

Despite good intentions and extensive efforts to develop suicide awareness and prevention programs for youth in schools, few programs have been evaluated to see if they work. Many of these programs are designed to reduce the stigma of talking about suicide and encourage distressed youth to seek help. Of the programs that were evaluated, none has proven to be effective. In fact, some programs have had unintended negative effects by making at-risk youth more distressed and less likely to seek help. By describing suicide and its risk factors, some curricula may have the unintended effect of suggesting that suicide is an option for many young people who have some of the risk factors and in that sense "normalize" it – just the opposite message intended. Prevention efforts must be carefully planned, implemented and scientifically tested. Because of the tremendous effort and cost involved in starting and maintaining programs, we should be certain that they are safe and effective before they are further used or promoted.

There are a number of prevention approaches that are less likely to have negative effects, and have broader positive outcomes in addition to reducing suicide. One approach is to promote overall mental health among school-aged children by reducing early risk factors for depression, substance abuse and aggressive behaviors. In addition to the potential for saving lives, many more youth benefit from overall enhancement of academic performance and reduction in peer and family conflict. A second approach is to detect youth most likely to be suicidal by confidential screening for depression, substance abuse, and suicidal ideation. If a youth reports any of these, further evaluation of the youth takes place by professionals, followed by referral for treatment as needed. Adequate treatment of mental disorders among youth, whether they are suicidal or not, has important academic, peer and family relationship benefits.

Are gay and lesbian youth at high risk for suicide?

With regard to **completed suicide**, there are no national statistics for suicide rates among gay, lesbian or bisexual (GLB) persons. Sexual orientation is not a question on the death certificate, and to determine whether rates are higher for GLB persons, we would need to know the proportion of the U.S. population that considers themselves gay, lesbian or bisexual. Sexual orientation is a personal characteristic that people can, and often do choose to hide, so that in psychological autopsy studies of suicide victims where risk factors are examined, it is difficult to know for certain the victim's sexual orientation. This is particularly a problem when considering GLB youth who may be less certain of their sexual orientation and less open. In the few studies examining risk factors for suicide where sexual orientation was assessed, the risk for gay or lesbian persons did not appear any greater than among heterosexuals, once mental and substance abuse disorders were taken into account.

With regard to **suicide attempts**, several state and national studies have reported that high school students who report to be homosexually and bisexually active have higher rates of suicide thoughts and attempts in the past year compared to youth with heterosexual experience. Experts have not been in complete agreement about the best way to measure reports of adolescent suicide attempts, or sexual orientation, so the data are subject to question. But they do agree that efforts should focus on how to help GLB youth grow up to be healthy and successful despite the obstacles that they face. Because school based suicide awareness programs have not proven effective for youth in general, and in some cases have caused increased distress in vulnerable youth, they are not likely to help GLB youth either. Because young people should not be exposed to programs that do not work, and certainly not to programs that increase risk, more research is needed to develop safe and effective programs.

Are African American youth at great risk for suicide?

Historically, African Americans have had much lower rates of suicides compared to white Americans. However, beginning in the 1980s, the rates for African American male youth began to rise at a much faster rate than their white counterparts. The most recent trends suggest a decrease in suicide across all gender and racial groups, but health policy experts remain concerned about the increase in suicide by firearms for all young males. Whether African American male youth are more likely to engage in “victim-precipitated homicide” by deliberately getting in the line of fire of either gang or law enforcement activity, remains an important research question, as such deaths are not typically classified as suicides.

Is suicide related to impulsiveness?

Impulsiveness is the tendency to act without thinking through a plan or its consequences. It is a symptom of a number of mental disorders, and therefore, it has been linked to suicidal behavior usually through its association with mental health disorders or substance abuse. The mental disorders with impulsiveness most linked to suicide include borderline personality disorder among young females, conduct disorder among young males and antisocial behavior in adult males, and alcohol and substance abuse among young and middle aged males. Impulsiveness appears to have a lesser role in older adult suicides. Attention deficit hyperactivity disorder that has impulsiveness as a characteristic is not a strong risk factor for suicide itself. Impulsiveness has been linked with aggressive and violent behaviors including homicide and suicide. However, impulsiveness without aggression or violence present has also been found to contribute to risk for suicide.

Is there such a thing as “rational” suicide?

Some right-to-die advocacy groups promote the idea that suicide, including assisted suicide, can be a rational decision. Others have argued that suicide is never a rational decision and that it is the result of depression, anxiety and fear of being dependent or a burden. Surveys of terminally ill persons indicate that very few consider taking their own life, and when they do, it is in the context of depression. Attitude surveys suggest that assisted suicide is more acceptable by the public and health providers for the old who are ill or disabled, compared to the young who are ill or disabled. At this time,

there is limited research on the frequency with which persons with terminal illness have depression and suicidal ideation, whether they would consider assisted suicide, the characteristics of such persons, and the context of their depression and suicidal thoughts, such as family stress, or availability of palliative care. Neither is it yet clear what effect other factors such as the availability of social support, access to care, and pain relief may have on end-of-life preferences. This public debate will be better informed after such research is conducted.

Can the risk for suicide be inherited?

There is growing evidence that familial and genetic factors contribute to the risk for suicidal behavior. Major psychiatric illnesses, including bi-polar disorder, major depression, schizophrenia, alcoholism and substance abuse, and certain personality disorders, which run in families, increase the risk for suicidal behavior. This does not mean that suicidal behavior is inevitable for individuals with this family history; it simply means that such persons may be more vulnerable and should take steps to reduce their risk, such as getting an evaluation and treatment at the first sign of mental illness.

Does depression increase the risk for suicide?

Although the majority of people who have depression do not die by suicide, having major depression does increase risk compared to people without depression. The risk of death by suicide may, in part, be related to the severity of the depression. New data on depression that has followed people over long periods of time suggests that about 2% of those people ever treated for depression in an inpatient hospital setting, the rate of death by suicide is twice as high (4%). Those treated for depression as inpatients following suicide ideation or suicide attempts are about three times as likely to die by suicide (6%) as those who were only treated as outpatients. There are also dramatic gender differences in lifetime risk of suicide in depression. Whereas about 7% of men with a lifetime history of depression will die by suicide.

Another way about thinking of suicide risk and depression is to examine the lives of people who have died by suicide and see what proportion of them were depressed. From that perspective, it is estimated that about 60% of people who commit suicide have had a mood disorder (e.g., major depression, bipolar disorder, dysthymia). Younger persons who kill themselves often have a substance abuse disorder in addition to being depressed.

Does alcohol and other drug abuse increase the risk for suicide?

A number of recent national surveys have helped shed light on the relationship between alcohol and other drug use and suicidal behavior. A review of minimum-age drinking laws and suicides among youths age 18-20 found that lower minimum-age drinking laws was associated with higher youth suicide rates. In a large study following adults who drink alcohol, suicide ideation was reported among persons with depression. In another survey, persons who reported that they had made a suicide attempt during their lifetime were more likely to have had a depressive disorder, and many also had an alcohol and/or substance abuse disorder. In a study of all non traffic injury deaths associated with alcohol intoxication, over 20 percent were suicides.

In studies that examine risk factors among people who have completed suicide, substance use and abuse occurs more frequently among youths and adults, compared to older persons. For particular groups at risk, such as American Indian and Alaskan Natives, depression and alcohol use and abuse are the most common risk factors for completed suicide. Alcohol and substance abuse problems contribute to suicidal behavior in several ways. Persons who are dependent on substances often have a number of other risk factors for suicide. In addition to being depressed, they are also likely to have social and financial problems. Substance use and abuse can be common among persons prone to be impulsive, and among persons who engage in many types of high risk behaviors that result in self-harm. Fortunately, there are a number of effective prevention efforts that reduce risk for substance abuse in youth, and there are effective treatments for alcohol and substance use problems. Researchers are currently testing treatments specifically for persons with substance abuse problems who are also suicidal, or have attempted suicide in the past.

What does “suicide contagion” mean, and what can be done to prevent it?

Suicide contagion is the exposure of suicidal behaviors within one’s family, one’s peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors. Direct and indirect exposure to suicidal behavior has been shown to precede an increase in suicidal behavior in persons at risk for suicide, especially in adolescents and young adults. The risk for suicide contagion as a result of media reporting can be minimized by factual and concise media reports of suicide. Reports of suicide should not be repetitive, as prolonged exposure can increase the likelihood of suicide contagion. Suicide is the result of many complex factors; therefore media coverage should not report oversimplified explanations such as recent negative life events or acute stressors. Reports should not divulge detailed descriptions of the method used to avoid possible duplication. Reports should not glorify the victim and should not imply that suicide was effective in achieving a personal goal such as gaining medial attention. In addition, information such as hotlines or emergency contacts should be provided for those at risk for suicide. Following exposure to suicide or suicidal behaviors within one’s family or peer group, suicide risk can be minimized by having family members, friends, peers, and colleagues of the victim evaluated by a mental health professional. Persons deemed at risk for suicide should then be referred for additional mental health.

Is it possible to predict suicide?

At the current time there is no definitive measure to predict suicide or suicidal behavior. Researchers have identified factors that place individuals at higher risk for suicide, but very few persons with these risk factors will actually commit suicide. Risk factors include mental illness, substance abuse, previous suicide attempts, family history of suicide, history of being sexually abused, and impulsive or aggressive tendencies. Suicide is a relatively rare event and it is therefore difficult to predict which persons with these risk factors will ultimately commit suicide.

Teen Suicide

Academy of Child and Adolescent Psychology

Suicides among young people nationwide have increased dramatically in recent years. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15-24 year olds, and the sixth leading cause of death for 5-14 year olds.

Teenagers experiencing strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up.

For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. In some cases, suicide appears to be a "solution."

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the symptoms of suicidal feelings are similar to those of depression. Parents should be aware of the following signs of adolescents who may try to kill themselves:

- Change in eating and sleeping habits
- Withdrawal from friends, family, and regular activities
- Violent actions, rebellious behavior, or running away
- Drug and alcohol use
- Unusual neglect of personal appearance
- Marked personality change
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Loss of interest in pleasurable activities
- Not tolerating praise or rewards

A teenager who is planning to commit suicide may also:

- Complain of being a bad person or feeling "rotten inside"
- Give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," and "I won't see you again"
- Put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- Become suddenly cheerful after a period of depression
- Have signs of psychosis (hallucinations or bizarre thoughts)

If a child or adolescent says, "I want to kill myself," or "I'm going to commit suicide," always take the statement seriously and seek evaluation from a child and adolescent psychiatrist or other physician. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than "putting thoughts in the child's head," such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems. If one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help when the concerns persist. With support from family and professional treatment, children and teenagers who are suicidal can heal and return to a healthier path of development

Suicide Warning Signs

Here is a list of potential warning signs. If someone only has one or two, they are not suicidal. Most suicidal people present a lot of them. Remember, do not diagnose someone, take them to a licensed doctor.

- Change in behavior
- Drug and/or alcohol abuse
- Change in eating and sleeping habits
- Persistent boredom, difficulty concentrating
- Talking about committing suicide
- Withdrawal from family or friends
- Unusual neglect of personal appearance
- Depression
- Giving away of possessions
- Expressions of hopelessness, excessive guilt.

Triggering Events

- Death of a parent, loved one
- Break up with boyfriend/girlfriend
- Extreme depression
- Failure in school and/or after school sports
- Sense of failure due to run-in with the law
- Feeling of extreme hopelessness
- Depression

There are a lot of different things that you can do to help someone who you think may be suicidal.

1. Don't diagnose them. Bring them to get checked out by a professional
2. Teach others about what to look for in ways of warning signs
3. Help them to figure out a way to solve their problems and deal with their pain
4. Take them seriously
5. Do not counsel the person yourself
6. ALWAYS express your love, concern and support for them.

Triggering Events Frequently Associated with Teen Suicide

Triggering events are not causes. No one knows *why* young people kill themselves. But we do know there is no one “cause” for a suicide. Instead, there may be a triggering event or series of events which prompts an impulsive or already at-risk teen to make an attempt. The cases where a teen attempts suicide exclusively as a direct result of, for example, a relational breakup or a fight with a parent are extremely rare. There are usually underlying risk factors which have more to do with this tragic result, including personality, genetic predisposition, pre-existing depression, or unusual stress.

Facts and Fables on Suicide

E.S. Shneidman

- FABLE:** People who talk about suicide don't commit suicide.
FACT: Of any ten persons who kill themselves, eight have given definite warning of their suicidal intentions.
- FABLE:** Suicide happens without warning.
FACT: Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions.
- FABLE:** Suicidal people are fully intent on dying.
FACT: Most suicidal people are undecided about living or dying, and they “gamble with death,” leaving it to others to save them. Almost no one commits suicide with letting others know how he is feeling.
- FABLE:** Once a person is suicidal, he is suicidal forever.
FACT: Individuals who wish to kill themselves are “suicidal” only for a limited period of time.
- FABLE:** Improvement following a suicidal crisis means that the suicidal risk is over.
FACT: Most suicides occur within about three months following the beginning of “improvement” when the individual has the energy to put his morbid thoughts and feelings into effect.
- FABLE:** Suicide strikes much more often among the rich – or conversely, it occurs almost exclusively among the poor.
FACT: Suicide is neither the rich man's disease nor the poor man's curse. Suicide is very “democratic” and is represented proportionately among all levels of society.
- FABLE:** Suicide is inherited or “runs in the family.”
FACT: Suicide does not run in families. It is an individual pattern.
- FABLE:** All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he is not necessarily mentally ill.

Tips for Parents

1. **Know the warning signs!**
2. **Do not be afraid to talk to your child.** Talking to your children about suicide will not put thoughts into their head. In fact, all available evidence indicates that talking to your child lowers the risk of suicide. The message is, "Suicide is not an option, help is available."
3. **Suicide-proof your home.** Make the knives, pills and above all, firearms inaccessible.
4. **Utilize school and community resources.** This can include your school psychologist, crisis intervention personnel, suicide prevention groups or hotlines, or private mental health professionals.
5. **Take immediate action.** If your child indicates he/she is contemplating suicide, or if your gut instinct tells you they might hurt themselves, get help. **Do not leave your child alone.** Even if he denies "meaning it," stay with him. Reassure her. Seek professional help. If necessary, drive your child to the hospital's emergency room to ensure that s/he is in a safe environment until a psychiatric evaluation can be completed.
6. **Listen to your child's friends.** They may give hints that they are worried about their friend but be uncomfortable telling you directly. Be open. Ask questions.

Tips for Teachers

1. **Know the warning signs!**
2. **Know the school's responsibilities.** Schools have been held liable in the courts for not warning the parents in a timely fashion or adequately supervising the suicidal student.
3. **Encourage students to confide in you.** Let students know that you are there to help, that you care. Encourage them to come to you if they or someone they know is considering suicide.
4. **Refer students immediately.** Do not "send" a student to the school psychologist or counselor. **Escort the child** yourself to a member of the school's crisis team. If a team has not been identified, notify the principle, psychologist, counselor, nurse, or social worker. (And as soon as possible, request that your school organize a crisis team!)
5. **Join the crisis team.** You have valuable information to contribute so that the school crisis team can make an accurate assessment of risk.
6. **Advocate for the child.** Sometimes administrators may minimize risk factors and warning signs in a particular student. Advocate for the child until you are certain the child is safe.