# Teen Suicidal Behavior

## A Survey of Oregon High School Students, 1997

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# Conclusions

**Youth at Risk**

Suicide is a persistent problem among Oregon's youth. Parents, educators, health care professionals, and others need to be aware that the changing social milieu is prompting more adolescents to consider suicide as an option.

> ***"I wish that I knew more about a lot of health Issues. I would like someone other then a school counsler to talk to. For Instance someone who's almost died becuse of suicide. I've almost died, and I get really depressed sometimes, I need someone who went through It to talk to."***

Among suicide attempters, there is a spectrum of desires, from cries for help to death. Many are ambivalent about ending their lives; they see suicide as the solution to their problems in life, but would rather live if a solution could be found. [36] There is a continuum of self-destructiveness (from subintentional to intentional) that can be measured in adolescents; these behaviors and characteristics relate to premature adult mortality, whether from natural, accidental or suicidal causes. In a recent study, measures of conduct problems and emotional instability were lowest for persons dying from natural causes of death, higher in persons dying from unintentional injuries, and highest among those who committed suicide. [37] Even if adolescents do not make overt suicide attempts, they may still engage in inherently risky and self-destructive behavior that requires counseling.

Youth Risk Behavior Survey data suggest that 2,500-3,500 Oregon high school students were treated for a suicide attempt during the 12 months prior to the survey. [38] These young Oregonians are a diverse population but often share certain characteristics that can be used in identifying those at risk and targeting them for counseling and intervention. *The best individual behavioral characteristics (from the YRBS) for identifying high school students at risk of making suicide attempts are: injection drug use, frequent use of inhalants, tobacco, or cocaine, as well as multiple pregnancies.*

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**MYTHS AND FACTS ABOUT SUICIDE**

Myth: People who talk about suicide don't kill themselves.
**Fact: Eight out of ten suicides have spoken about their intent before killing themselves.**

Myth: People who kill themselves really want to die.
**Fact: Most people who commit suicide are confused about whether or not they want to live or die. Suicide is often a cry for help that ends in tragedy.**

Myth: Once the depression seems to be lifting, would-be suicides are out of danger.
**Fact: At such a time, they are most vulnerable to a reversal: something can go wrong to make the person even worse than before. The person's apparent calm may be due to having already decided on suicide.**

Myth: When people talk about suicide, you should get their minds off it, and change the subject.
**Fact: Take them seriously; listen with care; give them the chance to express themselves; offer whatever help you can.** [32]

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> ***"I think my school has fabulous health programs; very informative. I think depression is a serious health issue that needs to be dealt with. I think it is probably the biggest health problem at my school."***

These are by no means the only risk factors associated with suicidal ideation and attempts ( Figure 10). Self-destructive behavior is also strongly linked with a number of other characteristics and life events, many arising in unfavorable home environments (See Appendix C).

A limitation of this study is the inability to identify the minority of students who engage in suicidal behavior but who do not exhibit any behavior or school problems. Instead, these youth, who may even be academic superstars, experience anxiety and may be rigid and perfectionistic. [39] Periods of change or dislocation can precipitate an attempt. [27] Like the Hispanic student with the 4.00 GPA (whose quote appears to the left), they may excel academically and not appear to be at risk. Recent studies have also shown that suicide has a genetic component, one that is independent of depression. [40, 41]

Some teenagers romanticize suicide, imagining a large funeral that will be attended by those who have been nasty or uncaring and who are now filled with remorse and sadness. They may also believe that they will be reunited with others who have died. Such romanticization can increase the risk of suicide. [42]

In a review of studies, certain personality traits were found to be particularly characteristic of suicide attempters: aggression or hostility, impulsivity, societal withdrawal or interpersonal difficulties , low self-esteem, dependency, hopelessness, external locus of control, rigid cognitive style, and poor problem-solving. [43] Exposure to a suicide or suicide attempt by a family member or friend may also trigger suicidal behavior. [44, 45] However, there is no "typical" suicidal adolescent. Each suicide is an individual act influenced by a diverse set of social and personal factors that are not always apparent.

> ***"Teens today do have a lot of problems. I am a 4.00 Hispanic American female student. People think I have it all going for me, but I have my problems. So many times I feel like, at school, there is no adult who I can just talk to - they say, "I'm so glad you're such a good student," but no one really wants to listen. I have a wonderful home life, but sometimes, I need a shoulder to cry on - beside them. What I'm trying to say, is that, just***

***because students may not drink, do drugs, or sleep around, they still may be `at risk' How can you help students like me?"***

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**Possible Verbal Hints of Impending Suicidal Behavior**

- I won't be a problem for you much longer.
- Nothing matters.
- It's no use.
- I wish I were dead.
- That's the last straw.
- I can't take it anymore.
- Nobody cares about me.
- I won't see you again.
- I wish I were never born.

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Threats or warning signs precede as many as 80% of suicide attempts and completions, and although the majority of the threats are not followed by actions, *all* suicidal communications should be taken seriously, responded to, and evaluated. [46]

Parents often do not recognize a child's suicidal symptoms or, if they do, may feel ill-equipped to intervene. [47, 48, 49] Yet without intervention, at-risk youth may commit suicide. School staff and youth themselves should also be aware of the indicators of potential suicide risk, and should tell those in a position to help if they see someone exhibiting signs of suicidal behavior. Health care workers, too, have an important role to play in ameliorating this self-destructive behavior. There is strong evidence that adolescents often seek general medical care shortly before their suicidal behavior. [50, 51] Primary health care providers should consider the potential for self-destructive behavior regardless of the adolescent's presenting complaint. [52] No less than 35% of Oregon attempters have made prior attempts. [53] A previous suicide attempt is the best predictor of future suicidal behavior; among attempters, 10% to 20% will ultimately die by suicide. [54] Without intervention, a failed suicide attempt may be followed by one that results in death.

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**WARNING SIGNS**
***possible indicators of increased suicide risk***

**Changes in behavior:**

- Accident proneness
- Drug and alcohol abuse
- Physical violence toward self, others, animals
- Loss of appetite
- Sudden alienation from family and friends
- Truancy, running away

- Worsening performance at school
- Putting affairs in order
- Loss of interest in appearance
- Disposal of possessions
- Letters, notes, poems with suicidal content
- Taking unnecessary risks
- Purchasing a gun

**Changes in mood:**

- Expressions of hopelessness, impending doom
- Explosive rage
- Dramatic highs and lows
- Becoming suddenly cheerful after a period of depression
- Crying spells
- Lack of sleep or excessive sleep
- Decline in self-respect

**Changes in thinking:**

- Difficulty concentrating
- Focus on morbid or death themes
- Hearing voices, seeing visions, expressing obviously false and bizarre beliefs
- Irrational speech
- Sudden interest or disinterest in church/religion

**Changes in life events:**

- Death of a family member or friend, especially by suicide
- Separation or divorce
- Loss of important relationship, including pet
- Public humiliation or failure
- Serious physical illness
- Loss of financial security

These signs must be interpreted in context. Obviously many of them are common outside the realm of pre-suicidal behaviors.

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**Suicide Mortality**

> ***"I think that there should always be someone that the teens trust becase teens always need someone to talk to about problems, if they aren't able to talk about their problems, it all just builds up inside and soon they will explode and eventually, they will end up being very depressed and that usually leads to teen suicide. The fact that they couldn't find some one that they could trust is very sad."***

Few Oregon communities have not been touched by the tragedy of youth suicide. In fact, the risk is greatest where resources are often most limited. Like adults, teens living east of the Cascade Mountains are at greater risk of suicide than those living in western Oregon. Compared to 10- to 19-year-olds living in the non-coastal areas of western Oregon, those in the eastern two-thirds of the state were 37% more likely to commit suicide ( Table 8 and Figure 11).

Most reported suicidal attempts by Oregon adolescents are made by overdosing with medications; about half of these attempts are made with analgesics, often acetaminophen (e.g., Tylenol). [53] Unfortunately, many youth are unaware of the potential long-term effects of drug overdoses (e.g., liver toxicity); in one study, 41% of high school students underestimated the potential lethality of acetaminophen, and 17% believed that one could not ingest enough of the drug to cause death. [55]

***"I think that I have wasted my life thus far and so I don't care anymore."***

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**CONTAGION** One risk factor that has been identified among adolescents is "contagion," a process by which exposure to suicidal behavior in one or more persons influences others to commit or attempt suicide. It can lead to clusters of suicides. [68] One important source of contagion is the news media; this does not mean, however, that media reporting of suicide should be curtailed. Rather, community efforts to address the suicide problem can be strengthened by news coverage that describes the help available in the community, explains how to identify persons at high risk of suicide, or presents information about risk factors for suicide.

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While 80% of non-fatal suicide attempts by Oregon's youth (under 18 years of age) during 1994-1996 involved ingestion of drugs, 68% of the attempts that resulted in death involved guns (See Appendix D). [56] Because of the high likelihood of death when guns are used, parents and others should restrict access to these highly lethal weapons among at-risk youth. When a gun is used, there is rarely a second chance. In only 30% of the homes of Oregonians where both guns and children are present are the guns stored unloaded and locked. [57] In another study, nearly one in four adolescents with a history of both substance abuse and suicide attempts lived with families who still kept a gun in the home. [58]

Increased availability of firearms in the home is one of the most frequently cited findings associated with both the observed increased incidence of youth suicide and the increased use of firearms in suicides. [58] Between 1959-61 and 1992-94, the suicide by gun rate for Oregonians of all ages increased 4.3 times faster than did the rate for other methods. [8]

**Prevention**

***"I think it would be neat if we could get a health center at our school."***

The Oregon Health Services endorses the American Academy of Pediatrics intervention strategies for the prevention of youth suicide. These strategies focus on five general areas: (1) basic education about suicide directed to the general public through such avenues as high school classes and television programming, (2) screening programs to identify individuals at high risk for suicide, (3) training of health care and community providers who serve as gatekeepers for intervention services, (4) treatment programs for those who have

attempted suicide, and (5) efforts to address firearm availability as a risk factor for suicide. [59] The data from the YRBS indicate that high school youth should have easy access to psychological services, regardless of their insurance status. [60]

***During the 1996-97 school year, 21% of all visits to state- supported school-based health centers were for mental health or mental health services, pointing to the need for on-site resources to service troubled youth.***

***"more kids are depressed & suicidal in this school then you people want to admit."***

Adolescence is a time of change during which teens may experience confusion, pressure to succeed, stress, self-doubt, financial insecurity, and an unsupportive family. Sometimes these pressures lead to suicidal feelings and depression, but both are treatable disorders. Affected children and adolescents need to have their illness recognized, diagnosed, and treated.

***"I think that our school and our community is living in fear of the parents. This is a small town which in our case means small minded conservative ideas and values. Parents think that they are hiding some thing from their kids or protecting them by not even metioning the subject identified in the survey, but in all actuality they are holding them behind and making the risk higher. If the parents had talked to them when they were in high school it could have cost them a lot less heart ache and pain. Wouldn't you think that they would want to give their kids a better life and talk withe them about thiese problems. Our parents are afraid to talk to us when little do they know that we really know a lot."***

During the 1997-98 school year, 39 schools had on-site school-based health centers to serve the medical needs of their students. Over one-fifth of all visits were for mental health care needs. Although thousands of students were treated, many more did not have access to school-based health centers. For additional information, see Appendix E. Most people feel uncomfortable talking about suicide and death, particularly when it involves a child. However, asking a child 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 provides assurance that somebody cares and will listen. [61]

Ideally, suicidal feelings should be recognized and treated before an attempt is made. If they are not, and the youth survives the attempt, then direct intervention at the time of the acute event is required. This should include treatment that addresses holistically the often broad spectrum of interrelated risk factors leading to the act.

In 1997, the Oregon legislature, for the first time, provided funding for a Youth Suicide Prevention Coordinator position within the Health Services. Please call 503-731-4021 for consultation in developing prevention programs, giving presentations, and providing training in crisis management.

The epitaph of too many suicides has been, "We didn't know."

**When a adolescent talks of suicide you should . . .**

**LISTEN:**

- Don't act shocked. This will put distance between you.

- Encourage the child to talk to you or to some other trusted person.
- Allow expressions of feelings. Don't give advice or feel obligated to find simple solutions. Try to imagine how you would feel in the child's place.

**BE HONEST AND DIRECT:**

- Talk openly and matter-of-factly about suicide.
- If the child's words or actions scare you, tell him or her. If you're worried or don't know what to do, say so. Don't be a cheerful phony.
- Offer hope that alternatives are available but do not offer glib reassurance.

**SHARE FEELINGS:**

- At times everyone feels sad, hurt, or hopeless. You know what that's like; share your feelings. Accept the child's feelings. Let the child know he or she is not alone.
- Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life.
- Get involved. Become available. Show interest and support.

**GET HELP:**

- Don't be sworn to secrecy. Seek support.
- Professional help is crucial when something as serious as suicide is considered.
- Help may be found at a suicide prevention and crisis center, local mental health association, or from a family physician.
- Become familiar with the suicide prevention program at the child's school. Contact the appropriate person(s) at the school.
- Take action. Remove means, such as guns or stock-piled pills. [62]