CALIFORNIA ASSOCIATION OF SCHOOL PSYCHOLOGISTS
RESOURCE PAPER

TEEN SUICIDES: LIFE, AFTER DEATH

It was played out like a scene from a modern-day Romeo and Juliet. Christian, 14, and Maryling, 13, were sweethearts who were forbidden to see each other. In early November 1995, they met one last time. They stood at the edge of a Florida canal, joined hands and jumped 15 feet into the cold, murky water to their deaths.

Their deaths may sound romantic to other teenagers. Some may even wish they were like Christian and Maryling. Others may go as far as copying the actions of the couple, with similar results. There is mounting evidence that teens do follow the suicidal actions of their peers, a trend known as suicide clusters or contagion.

Two Victorville, CA, 14-year-old girls had a suicide pact, and left 20 notes around town for several people to find. One of the notes was given to their best friend with instructions not to open it until a certain time. It was determined that one hour before that time is when the girls inflicted single gunshot wounds to their heads, completing their suicide attempts. This double-suicide occurred in March, and by the end of June, 30 children in the surrounding areas had been hospitalized for suicide attempts. And the trend continued. At the beginning of July, another child completed suicide.

Similar examples of contagion have been reported in Los Angeles. In San Pedro, a boyfriend and girlfriend, ages 15 and 16, jumped off a cliff in Palos Verdes. Five weeks later, two girls ages 14 and 15 jumped from a cliff to their deaths in a similar manner.

TEEN SUICIDES TRIPLE

According to the Centers for Disease Control and Prevention in Atlanta, GA., suicide among adolescents and young adults has nearly tripled between 1950 and 1992. From 1980 to 1992, suicide among American teens 15 to 19 years old rose 28.3 percent, increasing from 1,797 to 1,847. During that same time period, the suicide rate for children 10 to 14 has grown 120 percent, including 300 percent in African-American males, and 233 percent for white females. In 1992, the last year for which statistics are available, 304 children ages 10 to 14 years killed themselves. Suicide is now the third leading cause of death nationwide for 15 to 24 year olds; the second leading cause of death for children ages 11 to 19. Statistics gathered in 1994 show that among teens and young adults between the ages of 15 and 24, nearly 14 per 100,000 now complete suicides; in 1950 that number was only 2.7 per 100,000.

Although the CDC doesn't track attempted suicides among teens, a *Youth at Risk Survey*, commissioned by the Division of Adolescent and School Health at the National Center for Chronic Disease Prevention, shed some light on the depth of the problem. The 1990 survey questioned 12,000 high school students across the country. The startling results found that 28 percent of the students interviewed had seriously considered suicide in the previous year; 16 percent had made a specific plan, and 8 percent had attempted suicide. Of those, 25 percent reported an attempt that required medical treatment.

The alarming number of teen suicides may actually be gross underestimates because many suicides are recorded as accidents, according to Richard Lieberman, school psychologist and consultant to the Los Angeles Unified School District's (LAUSD) Suicide Prevention Unit. Even though the recorded number of suicides is alarming, Lieberman believes it could be much higher.

Lieberman cited an example in which a teen committed suicide on a school bus after a baseball game. He played Russian Roulette in front of his peers. Yet, Lieberman said, the

teen's death was listed as an accident.

"Youth suicide is swept under the table," Lieberman said in a recent interview. "Adults like to blame it on the music, the school or something else. They want to simplify it."

Because it is so difficult to cope with, adults are prone to underestimate the number of teen suicides, or decide it is a white, male phenomenon; or blame it on music, schools or drugs.

There are no easy answers to why certain children want to kill themselves. According to Lieberman, the Carnegie Foundation issued a paper in 1992 that listed an array of reasons why more children are at risk today: More kids are under greater pressure at younger ages with less parental supervision and support. The changes that have practically brought about the end of the nuclear family have given children added responsibility -- too much freedom, too soon, with few coping skills.

There are many other risk factors: a history of substance abuse, mental illness, exposure to suicide (or contagion), exposure to violence. Other reasons point to a sense of hopelessness, as well as the teen experience of stress, confusion, self-doubt, pressure to succeed, financial uncertainty and other fears. For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can intensify self-doubts. A lack of socially acceptable ways for youngsters to express anger, a lack of connection to religion, and the increasing mobility of the American family have also been cited. In some cases, suicide may be considered "a solution."

SHEDDING LIGHT ON TEENS' DESPAIR

A study of youth suicides in Oregon found that during 1990-93, the most commonly reported reasons for attempting suicide were family discord (59.4 percent), followed by an argument with a boyfriend or girlfriend (32.6 percent), and school-related problems (23 percent). More females and kids 12 years old or younger cited family discord as their reasons for attempting suicide.

The Oregon study, entitled *Fatal and Nonfatal Suicide Attempts Among Adolescents -- Oregon, 1988-1993*, and published by the CDC's *Morbidity and Mortality Weekly Report*, found that most suicide attempts were made in the home of the suicidal person (78.8 percent), followed by another residence, (7.4 percent), in school, (4.7 percent) and in jail (0.2 percent). Attempts occurred more commonly during the spring months and least commonly during the summer months. The attempts happened more often on Mondays, and least often on Saturdays.

The Oregon study went on to report that the ingestion of drugs accounted for more than 75 percent of the attempts, yet less than 1 percent of those attempts were fatal. However, of the 124 deaths among youths 17 years old or younger, 63.7 percent resulted from the use of firearms.

According to the Center to Prevent Handgun Violence in Washington, D.C., guns and troubled teens can be lethal. Ninety-two percent of all suicides nationwide (involving all age groups) attempted with guns are completed. Teens who have been drinking alcohol are five times more likely to use guns than any other suicide method. Every six hours, a youth aged 10-19 commits suicide with a gun. And the odds that potentially suicidal adolescents will kill themselves go up substantially when a gun is kept in the home.

"A tremendous factor in teen suicides is the increase in accessibility of guns in the community," Lieberman said. "We have to remember that this is a passionate age group. There is nothing more lethal than a 14-year-old girl who is despondent over breaking up with her boyfriend and who has access to a gun."

CONFRONTING SUICIDE CONCERNS

Lieberman's job at the LAUSD is to try to prevent and intervene in child suicides. He spends his

days counseling students, teachers, parents, administrators and anyone else who is interested on the growing youth suicide problem. He believes it's time that adults confront the issue and bring it out in the open, just as many are now dealing with teen-aged drug use and cigarette smoking.

California is one of only five states with youth suicide prevention legislation, and LAUSD is one of only a handful of districts in the country with an ongoing suicide prevention program. Lieberman and his colleagues are called on to speak to the three groups of people that children speak to -- kids, parents and school personnel -- about preventing suicide and how to successfully intervene.

One key, Lieberman says, is open, ongoing communication. Teens and younger children contemplating suicide often mention or even discuss their plans with a friend. Thinking they are helping their friendship, the friend will often keep confidential a friend's suicide plan. Lieberman reminds the group that the chances of their friend carrying out those plans are good if nobody works to stop those plans.

"I tell them that if they want to help their friend, they must not keep the secret, make no deals. They must tell their own parents, or the friend's parents or someone at school," Lieberman said. That is a difficult decision for some students to make. But Lieberman tells school crisis teams, students and others that the student who is contemplating suicide is not thinking clearly, and needs help.

The school psychologist said he, or anyone else, legally must tell someone -- a parent or guardian -- if a child tells him of plans to kill himself. Some parents are genuinely concerned when they get a call from him and are prepared to do what they can to help their child. Others have trouble accepting that their child might be contemplating suicide.

PARENTAL UNDERSTANDING IS CRITICAL

"Very often parents dismiss it," Lieberman said. "They say, 'he's just asking for attention.' 'Right,' I say, 'and if they don't get that attention, just see what he'll come up with next week.'"

Kids don't wake up suicidal, says Lieberman. "They get there after traveling a long road."

One key to prevention is to empower those around the child by sharing the warning signs. According to the Academy of Child and Adolescent Psychiatry, parents, teachers, administrators and school psychologists should be aware of the following signs in teens who may try to kill themselves.

- An indication that there have been previous attempts at suicide.
- Plans or attempts to secure a means for suicide.
- Thinking or talking about suicide.
- Scratching, cutting or marking the body.
- Risk-taking behavior, such as running into traffic, jumping from heights, running away or general and unusual rebelliousness.
- Withdrawal from friends, and family and regular activities.
- 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 "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," "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.

TAKING THREATS SERIOUSLY

The most important sign is to take a child or teen seriously if he or she says, "I want to kill myself," or "I'm going to commit suicide." Asking a 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 with an expert.

There are many strategies that can be taken by school personnel to deal with potential suicide problems. The National School Safety Center listed these suggestions in its November 1992 *School Safety Update* that can be used by school psychologists:

- Establish policies and procedures. Safety of students is of primary importance. Therefore, guidelines should specify the necessary steps to take when learning of potential danger. Responsibility requires action.
- Provide training for all staff regarding suicide warning signs and school procedures. This training can take place during scheduled in-service meetings. Include information on suicide statistics; an explanation of the need for training; suicide myths; appropriate and inappropriate staff conduct; school board policy regarding suicidal behavior; and confidentiality.
- Designate the persons who act upon suicide referrals. Additional training will be necessary for those who receive the reports of at-risk students. Each school plan should include some aspect of the following: confidentiality, interviewing techniques for dealing with the at-risk student; dealing with the parents alone and the parents with the student; presenting professional assistance plans to parents and students; and offering school support to the whole family.
- Contact treatment agencies. In crisis situations, a previously prepared list of resources is invaluable. Knowing what services are provided, costs, insurance requirements, admission policies and waiting periods will enable the school staff to save time.
- Develop a support program for threats and attempts. The student will remain at risk for some time after an attempt. The first three to six months is the most critical time, although some remain at heightened risk of suicide for at least two years. Often a completed suicide occurs just when the family and community feel that "things are beginning to return to normal." Programs that ease the return to school and regularly monitor the student, without causing embarrassment, will enhance the student's chances of receiving further help if needed.
- Identify contributory sources of student pain in the school environment. Honest assessment of the school environment may reveal areas or policies that cause inordinate amounts of stress to many students. Adjustments rather than lack of action are indicated.

CRISIS RESPONSE STRATEGIES

Despite good efforts, sometimes a student will commit suicide. Schools need to be prepared to deal with the tragedy. The National School Safety Center suggests that students and staff be

told of a suicide when information is confirmed. The news should be announced in classrooms by fully informed teachers. Discussion will ensue; suicide as a solution to problems should not be glorified.

Some upset students will want to go home. A caretaker should be notified to come to school to escort the student. School should not be dismissed, nor the schedule changed. The staff also should be made aware of the potential for contagion or suicide clusters, and to be especially sensitive to talk about suicide.

Support for those close to the deceased will be needed. The survivors of suicide frequently feel guilt and anger, as well as grief. They may be asking themselves how they could have intervened -- with a phone call or by winning more trust from the deceased. Feelings must be expressed and counseling will help the survivors' understanding.

Some students and staff will want to attend the memorial service, and this should be allowed. But both the National School Safety Center and Lieberman agree that no memorial service should be held at the school because it places the deceased student in the position of being a role model.

“When children think about suicide they are not thinking clearly. It is not a far stretch for a child who sees a beautiful tree, a yearbook dedication or a memorial plaque to imagine he or she will receive such attention in death,” Lieberman said. “This precedent could confuse a child who at such a young age does not understand the permanence of death.”

There are many people alive today who were suicidal at one time in their lives. Students should be encouraged to talk about feelings that could lead to suicide and to "save friends" by reporting plans their peers may have for such a disastrous event. A large part of the solution is to educate -- school administrators, psychologists, counselors, teachers, parents, families and friends -- on the prevention, intervention and postvention techniques now available. But most of all, everyone involved must be supportive and ready to listen.

California Association of School Psychologists, 1997.

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