

Adolescent Suicide: Signs, Causes, and Possible Responses

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For the past two years I have been responding to the requests of young people, parents, youth ministers, and educators for information on adolescent suicide—its causes, its signs, as well as effective measures for preventing it. Through the Office of Youth Ministry of the Archdiocese of Baltimore, I have presented numerous workshops on this subject to parish youth groups, parent groups, high school faculties, and Catholic high school students.

The large number of requests leads me to conclude that suicide is a major issue of concern and fear for young people and adults alike, that people are in great need of information, and that it is essential to the task of youth ministry and the entire ministry of the Church that we respond to this very real need. To deal openly with the issues involved gives young people and adults an opportunity to verbalize their fears, concerns, and misconceptions.

In this article I will present basic facts and information on adolescent suicide, followed by some materials and suggestions for their use. These materials should be helpful to anyone who interacts with young people in any area of professional ministry, in our communities and neighborhoods, and in our immediate families. I hope, then, that this article will prove useful to those looking for information for themselves, for others, or for inclusion in a workshop setting.

The Facts

Though there is some variation in the hard data, the following statistics reflect the latest information we have about the situation in the United States and give a clear view of the problem.

1) There are between twenty-one thousand and seventy-five thousand suicides in the United States annually. The first figure represents verifiable suicides, but it appears that most suicides go unreported to protect the reputation of the

family and the victim. (It has been suggested that most single-passenger car accidents and most drug overdoses are actually camouflaged suicides or attempts at suicide.)

2) There are approximately sixty-five hundred suicides among young people under twenty-five years old each year in the United States. According to the National Center for Health Statistics, the rate rose 66 percent in the 1970s. This increase is due to both more actual suicides and more honesty and accuracy in reporting suicide as suicide.

3) Suicide is the third leading cause of death among young people (or second, according to some statistics, behind accidents). It is also the second leading cause of death for college students. Given the tendency toward camouflaging possible suicides as accidents and drug overdoses, suicide may well be the leading cause of death for young people.

4) On a daily basis, approximately eighteen young people kill themselves.

5) For every actual suicide, there are approximately fifty attempts. Therefore, it is estimated that there are nine hundred attempts daily by young people.

6) Girls attempt suicide three times more often than boys, while boys commit suicide three to four times more frequently than girls.

7) Nine out of ten suicide attempts by young people occur in the home. Of these, seven occur when the parents are home, between the hours of three o'clock in the afternoon and midnight. This fact is significant, suggesting that suicide is not necessarily an attempt to die as much as it is an attempt to get help.

Suicide as a Response

Suicide marks the end of an *unsuccessful struggle* to achieve a sense of self-esteem and of positive self-regard, and a feeling of being loved and lovable. It is the ultimate escape from the chronic problems of

daily living, of tolerating frustration and despair.

Suicide is an act of communication, a message that says "please notice me—please pay attention to me." Too often, when a child's behavior indicates a desire for attention, we are told just to ignore the child and the behavior, as if attention is not something the child deserves. Yet attention is a sign of being wanted and lovable and is, therefore, one of a child's basic needs. We need, then, to pay more attention to what our children's behavior is indicating.

For some young people, suicide is an act of *revenge* (usually against the family or an estranged peer), and for others, an act of romance. Young people tend to have an immature concept of mortality. They lack a realistic understanding of death. Suicide seems a way out—a painless end to the problems and pains of everyday living.

Suicide (and attempted suicide) has been described as the culmination in a person's life of progressive family disorganization, social maladjustment, and personal deterioration. Causes of stress, such as problems at home, in school, or in one's personal relationships, can lead to feelings of low self-esteem, being unloved, rejection, anger, withdrawal, being trapped, loneliness, guilt, and depression. These feelings can manifest themselves in such negative behaviors as drug or alcohol use, indiscriminate sexual activity, delinquency, running away (over one million young people run away annually), eating disorders (anorexia), depression, and suicide.

The pattern begins with unmanageable stress in one's life that leads to negative feelings about oneself. These feelings demand expression, either in active destructive behaviors, or in more passive, sometimes less noticeable behaviors. Suicide can be the end point of this pattern of stress and negative feelings.

The most common factor in the continuing chaos and unhappiness in the young person's life is his or her perception of a lack of parental understanding and appreciation. Blocked communication is often *the* factor in adolescent suicide, which suggests that the relationship between young people and their families is the key to healthy emotional and psychological development.

Good communication fosters a more open and trusting relationship between

parents and teens. It encourages the sharing of important issues and problems and allows the young person to express concerns and needs. Effective listening requires a nonjudgmental acceptance of another's feelings, with support and genuine concern. Parents need to engage in such communication with their teen to gain an understanding of his or her world, while showing a genuine interest in and a caring for the young person. Moreover, communication is a teachable skill; effective listening can be learned.

The Suicidal Person

Two contradictory and powerful feelings are at work within a person who is suicidal: first, *The only way out of my problems is to kill myself*, and second, *I want help to keep from killing myself*. The balance between these opposing feelings is very delicate. It is important to realize that any truly caring intervention we make in the lives of young people tips the balance toward life. For suicide is *not* pro-death as much as it is anti-life, and any time we can intervene with concern and compassion, we offer a sense of hope.

Suicidal persons make this verbal or nonverbal communication (either an attempt at suicide or talk about it) for the purpose of inviting concern and inquiry into their lives. If such concern is not forthcoming, this becomes another sign of rejection. People are not driven to suicide by inquiries as to whether or not they are suicidal as much as by others' avoidance of them and denial of their distress, which implies rejection.

Adolescent suicide is *not* an impulsive act. It is the culmination of long periods of maladjustment; inability to deal with stress; and problems with parents, relationships, peers and/or school. Many warning signs are usually given, so that most adolescent suicides could be prevented. But many young people who are hurting are just not talking to someone about their concerns and their pain. Thus the first line of psychological mental health, the first step in the healing process, is the opportunity to verbalize the problems and the feelings.

Many stories have appeared in the media about the "epidemic" nature of adolescent suicide. One suicide gives permission for the unthinkable. It makes suicide an option for some young people who may not have previously considered

it. In every school or church there probably are certain young people who, because they feel depressed, alone, or misunderstood, are at risk for suicide or other self-destructive behaviors. A recent school study stated that 10 percent of children between the ages of six and twelve had thought about suicide. We need to see suicide and attempts at suicide as barometers of many other preadolescent and adolescent disorders and problems.

Distress Signals

Mary Giffin and Carol Felsenthal, in their book *A Cry for Help*, identify three types of distress signals in the suicidal young person (adapted from chapter 3, pp. 39-74).

General Distress Signals

- acting out and aggressive, hostile behavior
- alcohol and/or drug use (second to depression as a spur)
- passive, apathetic behavior
- changes in eating or sleeping habits
- fear of separation (an issue in our mobile society)

Specific Behavior Changes

- abrupt personality changes
- sudden mood swings
- impulsive behavior
- slackening interest in school or play
- inability to concentrate
- loss of or lack of friends

The above two sets of behaviors and feelings can be observed in varying degrees and combinations in all young people, and they should be helped to understand that it is normal to experience them. But it is when they occur over an extended period of time in combination with the third set of behaviors that response and concern are extremely important.

Final Precipitants to Suicide

- loss of an important person or thing in one's life
- deep sense of hopelessness
- obsession with death or a death wish
- making out of a will (giving away prized possessions)

A Pattern

A three-step pattern occurs in the individual who attempts suicide. We can observe it if we use our eyes, our ears, and our

heart. We need to be aware of the person's behaviors, thoughts, and feelings.

First: There is a distinct change in behavior (general and specific distress signals).

Second: There is a precipitating event, an experience of "unbearable loss." This loss can be literal (as in the death of a loved one) or figurative (as in divorce, separation, rejection, moving to a new school or neighborhood, the loss of a friend, or the loss of feeling important or loved).

Third: There is access to and unobserved time with a lethal method.

Response

If we are aware of the signals and the pattern that point toward possible suicide attempts, we are more able to respond effectively. Our response can be understood in terms of intervention, prevention, and ministry.

Intervention

An intervention is the immediate response to an actual or possible suicide attempt. Intervention requires that we do something—and do it immediately. It means a medical response to the actual self-destructive behavior. It means also the physical response of removing the lethal method when a person has a plan for suicide. And it requires that we do not leave the person alone. We remove the occasion and the method (third step in the pattern), to allow for professional intervention by a hospital, a treatment program, or qualified counselors.

Thus we need to know where to go for extended help for the suicidal person. We need to know the community mental health centers, the suicide prevention programs, and other resources available for intervention. It is also important to avoid moralizing with the suicidal person ("It's wrong to . . .") and rationalizing ("It's just a phase—you'll grow out of it"). We need to give a sense of hope—to offer a sense of "Hang on . . . it'll pass, and I'll help you hang on." Intervention requires a very direct and immediate response to the suicidal person as well as to the survivors (family and friends) of an actual or attempted suicide.

Prevention

The prevention of suicide and suicidal tendencies in an individual takes several forms. It includes alleviating stressful

situations within the family, at school, and with peers before they become overwhelming, as well as supporting his or her coping mechanisms. Depressed individuals suffer from *tunnel vision*: they are unable to see options and possible solutions to their problems.

In a preventive approach, we enable individuals to define or redefine their problems in order to help them cope. If we can widen their vision, remove their blinders, enable them to make choices, we give them a sense of personal power that is the antithesis of depression. We need also to remove the romance from suicide. Suicide is painful, disfiguring and permanent; it needs to be demythologized.

Our single most important resource in the prevention of suicide is *our personal relationship with the individual*. Our relationship should foster the acceptance of the person and let him or her know that we care and that we are willing to help. It should be an experience of genuine concern that expresses our willingness to listen and understand the hurting person's feelings. We need to allow the person to talk about his or her problems and suicidal thoughts. The person needs to *name* the thoughts and the feelings. In a helping relationship, the person can verbalize and ventilate the interior pressure.

In entering this relationship, we, as the helper, must remain calm, balanced, and personally secure. If we choose to be the anchor for another, we need to be certain that we have an anchor for ourselves. We need to be aware of *our own* needs and take care to find our own support.

It is very important in prevention that we *involve others in supportive roles*. Depressed persons usually have a distorted perception of what others in their life think of them. They are convinced that no one cares, that no one is willing to help, and that they are not worthy of another's concern. A significant contribution we can make to these persons is to help them share their problems and concerns with other important people in their lives.

This involvement of other people in supportive ways demonstrates that others do care and also temporarily reduces the depressed person's responsibilities. And the added involvement provides more supervision and less opportunity for the suicidal act. It allows for time to resolve issues and adjust to loss. Involving others provides support not only for the suicidal

person but also for the person who is the initial contact and helper. This guiding of the hurting person into a network of concerned adults has very significant implications for our ministry to young people.

Ministry

There is also our "ministry response." Several characteristics that make youth ministry effective—either in the parish or the school—are also integral to the initial responses to suicide attempts or to suicidal tendencies.

In all our programs, *developing a sense of community* is key. Our parishes and schools must be places where young people feel a sense of belonging and a sense of concern and care. The fostering of a network of relationships among young people and with adults is integral to developing community.

One of the most important ways of creating this sense of belonging is through the *ministry of wasting time*. It is the time we "waste" on our young people that makes them feel important and enables a relationship based on acceptance and trust to develop.

It is also through this "creative loafing" that we most easily hear of the problems and concerns of young people. As adults in ministry to youth, we must be available and accessible. We must be approachable and able to listen to their verbal and nonverbal cries for help. Many of these cries will occur outside of our structured programs. So we must be able to establish personal, individual, and specific contacts with our young people, beyond the settings of the program or the class, in order to be more effective ministers.

When possible, we need to develop programs in *peer counseling* or *peer ministry*, which enable young people to gain the communication skills necessary to be immediate ministers to one another. Young people can watch for others in need if we teach them the skills and the signals to be aware of. They are usually the first to know that a peer is hurting, so we need to give them the skills to respond. And perhaps the most important of these skills is knowing where to go for help.

Our parishes and schools could sponsor *workshops for parents and teens*, to educate parents about the concerns, the needs, and the developmental issues of youth, as well as to sensitize young people to parental concerns. Such workshops

should foster the more effective communication between parents and young people that is so essential to alleviating stressful situations at home.

We need also to educate our parish and school staffs, as well as our young people, about the signs of, the causes of, and the helpful responses to adolescent depression and suicide. Most important, we must develop good referral patterns. We are not experts—we must know where to go for extended professional help. We must know our community resources.

Conclusion

Many of our young people are wounded because their basic need to feel and express love has not been fully met. Many are damaged by events and experiences in their lives. The issue is not one of assigning blame or guilt, but rather of fostering healing and reconciliation. The question we need to ask is, Who will love this child back to health?

The scriptural challenge of unconditional love demands that we “expect nothing and accept everything.” Our young people must see love as a free gift, offered individually and specifically to each of them. It is a gift offered by us as ministers and through the faith community. It is a gift that is not earned by certain actions or behaviors and not “unearned” because of certain actions or behaviors.

The challenge for us is to offer the gift of love because our young people are sacred persons. We need to see the sacred in our youth and to enable them to see their own sacredness. We need to see what it is we are doing as schools and parishes, as Church, that is conducive to healthy psychological, emotional, social, physical, and spiritual development in young people. We need to see what we are doing, and what more we can do, to foster the sense of their own sacredness in our young people.

Additional Materials and Their Uses

Reflection Questions

- Have you ever known someone who attempted or committed suicide? How did you feel when it occurred?
- Have you ever known someone in a deep depression? What were the signs or signals that indicated a serious depression? How did you feel? How did you respond?
- Why is it important to talk about depression and suicide?

- What do you think a person who attempts or commits suicide is trying to communicate?
- How else might a person get the desired attention, help, or attention from family and friends without resorting to suicide?
- List the places or persons you could suggest to a friend, or could turn to yourself, for help.
- Should you break a confidence when a friend indicates that he or she is contemplating suicide? Should you tell someone, if your friend asks you not to?
- How would you tell your friend that you care enough to get more help? (“What you are telling me is scaring me. I care about you, but we need more help. I’ll go with you, we need more help.”)
- How can we cope with stress in our lives? How do you stay physically, mentally, emotionally, and spiritually healthy?
- What is our school (parish) doing that is conducive to healthy psychological, emotional, physical, social, and spiritual development?
- What should you do if a friend attempts suicide? (Don’t ignore or deny the attempt. Also, know who you can talk to about your feelings.)

Role-plays

- A friend confides in you that she is thinking about suicide. What do you say and do?
- A friend asks that you not tell anyone else of his suicidal plans. How can you convince him that you must get more help and that you care?
- You feel you must tell a friend’s parents of her serious depression and suicidal thoughts. How would you do that?
- A friend seems very withdrawn and depressed. How would you initiate a conversation? Your friend says “Nothing is wrong, I’m fine.” What do you do then?
- A friend attempts suicide. What do you do and say?
- You are in a group that is discussing another student’s suicide attempt. They are making jokes about the failed attempt. What do you do or say? What do you think is going on with the group?

Groups should be encouraged to create their own role-plays, since they can more accurately reflect their real situations.

Myths and Realities

- 1) Myth: Nothing could have stopped the person, once he or she decided to commit suicide. (Reality: The person is pulled between two poles—wanting to end life and wanting help to keep from ending life.)
- 2) Myth: People who talk about killing themselves never do. (Reality: Eight out of ten suicides give definite warnings.)
- 3) Myth: When someone talks about suicide, it’s for attention, so ignoring it is best. (Reality: He or she wants and needs attention.)

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4) Myth: Talking to a troubled person about suicide may give him or her morbid ideas. (Reality: It is dangerous *not* to talk about what thoughts already exist.)

5) Myth: People under the care of a psychiatrist or a counselor rarely commit suicide. (Reality: It depends partly on the nature of the relationship, particularly on the level of trust.)

6) Myth: Suicides often occur out of the blue. (Reality: Usually there are many clues and warnings.)

7) Myth: People who commit suicide are insane. (Reality: Depression is not psychosis.)

8) Myth: Once a person tries and fails to commit suicide, shame and pain prevent further attempts. (Reality: Four out of five suicides were preceded by prior attempts.)

9) Myth: The person looks happier; the depression must be over. The danger is past. (Reality: Most suicides occur within three months of "improvement.")

10) Myth: Only a certain type of person commits suicide. (Reality: Suicide crosses socioeconomic and religious backgrounds.)

11) Myth: Suicides are mainly old people with only a few years to live. (Reality: Suicide rates peak in the twenties, level off into the fifties, and then climb again.)

12) Myth: Suicide runs in the family, so you can't do much to prevent it. (Reality: Suicide is an individual pattern, although prior suicides give permission.)

13) Myth: Once a person is suicidal, he or she is suicidal forever. (Suicide is a time-limited state of mind.)

Suggestions for Using These Materials

The information, reflection questions, and role-plays can be combined in various ways to respond to the needs of particular groups. The following sample combinations are suggested:

1) With a large group and limited time, poll the group to ascertain how many of them have had direct contact or knowledge of an actual or attempted suicide. Some people may be comfortable enough to share some of the story. Information about suicide can be presented in handouts, on newsprint, or on overhead transparencies. Time should be set aside for questions from the group.

2) When working with smaller numbers and more time, participants can share their

responses to the reflection questions in groups of six. Each group can appoint a recorder who reports to the large group about their discussion. The workshop leader can present information prior to or following the small-group discussion, and time should be allowed for questions.

3) Individuals or small groups can present the role-plays, allowing for large-group responses or suggestions after each role-play. Role-plays can be combined with reflection questions and the presenting of information.

The reflection questions and role-plays can be adapted to an adult audience of teachers, parents, or parish staff members. Whether it's geared toward youth, adults, or a combination of both, the workshop should allow for the participants to verbalize their questions and concerns and receive correct information in order to dispel myths. Young people and adults need opportunities to deal with this tragic, but very real, issue.

Resources

Alvarez, A. *The Savage God: A Study of Suicide*. New York: Bantam Books, 1973.

Giffin, Mary, and Carol Felsenthal. *A Cry For Help*. New York: Doubleday and Co., 1983.

Giovacchini, Peter. *The Urge to Die: Why Young People Commit Suicide*. New York: Macmillan Co., 1981.

Guest, Judith. *Ordinary People*. New York: Ballantine Books, 1977. This novel about the suicide attempt of a suburban teenager and the effect on his family is also a movie available on videocassette.

Inside, I Ache. Baltimore: Mass Media Ministries. This film program for exploring the subject of teenage suicide can be obtained from Mass Media Ministries, 2116 North Charles Street, Baltimore, MD 21218.

Mack, John E., and Holly Hickler. *Vivienne: The Life and Suicide of an Adolescent Girl*. Boston: Little, Brown and Co., 1981.

Rabkin, Brenda. *Growing Up Dead: A Hard Look at Why Adolescents Commit Suicide*. Nashville: Abingdon Press, 1979.

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