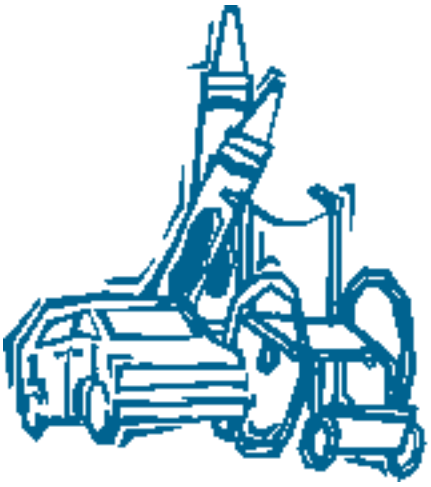

FAMILY

Youth and Suicide

no. 10.213

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Quick Facts...

Eight 10- to 15-year-olds and 39 15- to 19-year-old Coloradans took their own lives in 2000.

Each year approximately 600 Coloradans die by suicide.

Colorado counties with the highest suicide rates between 1991 and 200 were: Alamosa, Chaffee, Cheyenne, Costilla, Delta, Dolores, Gilpin, Montrose, San Miguel, Sedgwick, and Teller.

Friends and family members can learn to identify early warning signs of youth depression and suicide.

By knowing how to respond, friends and family members can help young depressed friends choose to live.

Colorado State University Cooperative Extension

Suicide is the second-leading cause of death among children, teenagers, and young adults in Colorado, second only to motor-vehicle traffic related accidents (Colorado Trust, 2002, pp. 4 and 14). Every year in the United States 250,000 youth attempt suicide. Of those in the 15 to 24 age group, 5,000 die per year. This means that every day close to 14 of our young people die by suicide. It also is known that children under 15 think about, attempt and commit suicide. The frequency goes up with age. According to recent studies, 13 percent of Colorado's young males and 25 percent of Colorado's young females (grades 9-12) thought about suicide in 2001 (Colorado Trust, 2002, pp. 11-12). Nine percent of young males and 19 percent of young females made a suicide plan. Seven percent of young males and 14 percent of young females attempted suicide in 2001 (Colorado Trust, 2002, pp. 11-12). Eight 10- to 14-year-old and 39 15- to 19-year-old Coloradans took their own lives in 2000 (http://www.cdphe.state.co.us/hs/hsshom.asp).

Most experts believe, however, that many suicides can be prevented. Parents and those interested in youth can act as the first line of defense in stopping this fatal act. It is essential to know the causes, warning signs and what to do if one suspects suicidal thinking.

The Rocky Mountain region has the highest suicide rate in the country. Colorado's suicide rate at 14.4/100,000 was 36 percent higher than the national average at 10.6/100,000 in 1999, which makes it 12th highest in the nation at roughly 600 deaths each year from suicide (Colorado Trust, 2002, p. 14). The largest number of suicide deaths occurs among middle-aged men 35 to 44 years of age. They are also the least likely to seek mental health counseling. The risk of suicide death increases among men as they get older and is particularly high among men 75 years and older. Most are white and not married. The leading external cause of death for Colorado ranchers and farmers has been suicide. Historically, suicide is the most frequent cause of death on farms and ranches (T. Daniels, 8/22/2000 e-mail communication). This was the case for 1999 with 7 of 28 rural deaths in Colorado reported as suicides. Livestock and tractors were the second and third leading causes of death in Colorado rural areas (T. Daniels, 8/22/2000 e-mail communication and Colorado Department of Public Health and Environment).

The primary reasons for not seeking professional help that were given by people who considered suicide include the following. "I wanted to solve the problem on my own." "I thought the problem would get better by itself." "Getting help is too expensive." "I'm unsure about where to go for help." "Help probably would not do any good." "It would take too much time or be inconvenient" (Colorado Trust, 2002, p. 24).

Table 1: Warning signs.

Verbal

"I wish I were dead."
"You don't have to worry about me any more."
"How do you leave your body to science?"
"Why is there such unhappiness in life?"

Feelings

Depression.
Sadness.
Loneliness.
Extreme boredom.
Sudden happiness after long period of depression.

Behaviors

Previous suicide attempt.
Giving away prized possessions.
Arranging to donate organs.
Making a will.
Alcohol or other drug use.
Careless, risk-taking behavior.
Withdrawal from family and friends.
Running away from home.
Change in school performance.
Extreme irritability, guilt, crying, inability to concentrate.
Violent and rebellious behavior.
Collecting pills, razor blades, knives, ropes or firearms.

Situations

Recent suicide or death of someone a youth respects or is close to.
Being a victim of physical or sexual abuse or rape.
Troubled family life.
Social isolation, lack of close friends.
Recent loss of job, friendships.
Failing or dropping out of school.
Not making a team or membership in an organization.
Unwanted pregnancy or abortion.
Being a "perfectionist."

Diekstra and Hawton, 1987; McBrien, 1983; Neiger and Hopkins, 1988; Ray and Johnson, 1983; Patros and Shamoo, 1989.

Counties with the highest suicide death rates between 1991 and 2000 are scattered throughout Colorado (Alamosa, Chaffee, Cheyenne, Costilla, Delta, Dolores, Gilpin, Montrose, San Miguel, Sedgwick, and Teller). Counties with the lowest suicide rates between 1991 and 2000 include Jefferson, Arapahoe, Douglas, Eagle, Summit, and Park Counties. These counties experienced rapid population growth and economic prosperity during those 10 years (Colorado Trust, 2002, p. 16).

It is believed that the increase in adolescent suicides relates to: 1) poor outlook for success in the future; 2) increasingly fast-paced society with youth feeling unprepared for too many changes and options; 3) pressure to succeed; 4) lack of support systems; and 5) family alienation (Blumenthal & Kupfer, 1988).

Reasons for Suicide

Adolescence is filled with many changes and is a vulnerable time for youth. There are great changes in physical characteristics, changes in the way they think, changes in expectations placed on them, increasing responsibilities, and the move toward greater independence. Becoming more independent of adult support and care is one of the hardest things for a youth to do. On the other hand, it is one of the most important developmental tasks for a youth to accomplish. These twin motivations often lead to great emotional anxiety. Lots of understanding is needed.

The way adolescents think is unique and can contribute to suicide. Of particular importance is their egocentric thinking, identified as "personal fable thinking" (Muuss, 1988). Adolescents are prone to exaggerate the importance or significance of their own thoughts and feelings. This often leads them to believe that they are completely unique, that there is no one like them or no one who has experienced the intensity of their feelings.

Also, some families' communication rules do not permit the suicidal person to state his or her needs openly to others. Thus, adolescents believe that there is no one who can understand them. This often creates a sense of intense aloneness and isolation as they face problems. Furthermore, the personal fable often relates to a belief that they are indestructible. Their belief that no one can understand them leads to feelings of loneliness and the decision not to seek needed help. Furthermore, many youth believe that suicide is somehow romantic or heroic. They may fail to comprehend that death is irreversible and perceive death like a peaceful sleep that will make everything better.

Some suicidal thoughts are not very serious, others are. Adolescents often have few life experiences and poor problem-solving skills. Their thinking is oriented to the present rather than the future. They have needs for immediate solutions. Many adolescents mistakenly believe that suicide is an acceptable solution to problems.

Some of the reasons youth give for thinking of suicide as a solution to problems are: to make others feel sorry, to make others know how desperate they are, to influence others, to make the pain go away, not knowing what else to do, to show how much they love someone, revenge, to make things easier for others, to be with someone who died, to die (Diekstra, & Hawton, 1987).

Depression is the leading cause of suicide, suicide attempts, and suicidal thinking in youth (Martin & Dixon, 1986; Stivers, 1988). It is critical to be able to recognize the symptoms.

Depression may be more concealed in the adolescent and viewed as a phase related to the frequent mood swings often experienced by

Myths and Facts About Youth and Suicide

MYTH: Adolescence is a trouble-free time of life.

FACT: Adolescence can be the most "roller-coaster" time of life.

MYTH: People who talk about committing suicide never do it.

FACT: When someone talks about committing suicide, they may be giving warning signals that should not be ignored. It is a way of asking for help.

MYTH: Talking to someone about suicidal feelings will cause him or her to commit suicide.

FACT: Asking someone about suicidal feelings may help the person feel relieved that someone finally sees his or her emotional pain.

MYTH: People who make suicide attempts are only looking for attention.

FACT: Suicide is an indication that all other ways of getting help have failed.

MYTH: There is a typical type of person who commits suicide.

FACT: The potential for suicide exists in all of us. Prior suicide attempts or suicidal behavior in the family can increase the risk.

MYTH: Improvement following a suicidal crisis means the risk is over.

FACT: Most suicides occur within about three months following "improvement." Having made a suicide decision, they may feel relieved that the pain will end.

MYTH: All suicidal individuals are mentally ill, and suicide is the act of a psychotic person.

FACT: Although extremely unhappy, this person is not necessarily mentally ill.

MYTH: All suicidal people want to die, and there is nothing that can be done.

FACT: Most suicidal people are ambivalent, that is, part of them is saying "I want to die," and part is saying "I want to live."

MYTH: All suicides occur without warning.

FACT: Many people, including adolescents, give warning of their suicidal intent (Martin & Dixon, 1986; Patros & Shamoo, 1989).

adolescents. Having the blues can be a normal experience when it doesn't last long. When it is long-term and intense, it is identified as depression.

Some factors related to depression are events perceived as losses with negative meanings. Some examples of events perceived as losses are: loss of a loved one or a relationship; unwanted pregnancy or abortion; or events that lower self-esteem (school expulsion, failure to make a team, academic failure, or not being invited to a popular social event) (Stivers, 1988). Any one of these events can be seen as either an opportunity or a crisis.

When youth experience little or no control in the important events of their lives, they may see themselves negatively. "I'm worthless. I'm no good." This negative thinking makes it difficult for youth to face the stresses in their lives, and combined with poor problem-solving skills can lead to feelings of depression and hopelessness (Patros & Shamoo, 1989).

Thinking and behavior tend to go together. Some of the behavioral symptoms of depression in adolescents include: acting-out, delinquency, anger, sexual promiscuity, alcohol and other drug use, withdrawal from normal activity and social contact, sleep disturbances, decreased or increased appetite, drastic changes in appearance, loss of energy (Martin & Dixon, 1986; Patros & Shamoo, 1989).

Not all depressed youth try to kill themselves. But the majority of youth who do attempt suicide experience depression.

Alcohol and other drug use can increase the risk of suicide, especially if used to escape pain. The substances create a change in consciousness. When this change no longer allows them to escape their pain, they may resort to a more drastic measure, suicide. Those involved in substance use tend to be more impulsive, easily frustrated, and lacking in self-control. The substance itself may be the chosen method of suicide.

Guidelines

The majority of youth who commit, attempt or think about suicide give signs of their intentions. However, they may give different signs to different people, making it difficult to put all the signs together. That is why it is so important to pay attention to any signs that indicate a youth may be having thoughts of suicide (Patros & Shamoo, 1989).

There is no complete list of symptoms for any youth. There is usually no single cause or a signal of suicide or suicidal thinking. Often it is difficult to determine whether a behavior is typical of adolescence or of serious concern. If you suspect that a youth in your family or a friend may be suicidal or experiencing depression, you may feel scared, nervous or anxious. These are normal feelings. Following are some general guidelines on what to do and what not to do when you find yourself concerned about a young person's being depressed or suicidal.

Do:

- Take all threats seriously.
- Notice signs of depression and withdrawal.
- Be concerned if there is recent loss in the youth's life.
- Trust your own judgment.
- Tell parents, guardians, guidance counselors, etc.
- Express your concerns to the youth by being an active listener and showing your support.
- Be direct. Talk openly and freely and ask questions about the person's intentions.

- Try to determine if the person has a plan for suicide (how, when, where). The more detailed the plan, and the more deadly the means, the more serious the threat.
- If safety permits, remove the means of suicide.
- **Get professional help.** Seek help from a school counselor, family therapist, psychologist, physician, trusted minister, priest, rabbi or crisis center to help solve the problems. Stay in close touch with the youth. Post community resource numbers by the phone: police, poison control, fire department, local crisis help-lines, mental health centers.

Don't:

- Ignore or explain away suicidal behavior or comments.
- Ignore verbal and behavioral warning signs.
- Assume that a youth will easily get over a loss.
- Be misled.
- Be sworn to secrecy.
- Attempt to impose guilt by preaching or debating the rightness or wrongness of suicide.
- Act shocked at what the youth may say to you.
- Assume that the youth will be all right left alone.
- Leave the means of suicide available to a youth.
- Assume because others become involved that the youth no longer needs your help (Patros & Shamoo, 1989).

The primary purpose of professional intervention is to assess the seriousness of the youth's situation and help him or her and the family through the crisis. Immediate action depends on the professional's assessment of the situation. It is most important for all involved to realize that even though the initial "suicide crisis" may have passed, the underlying problems and feelings still exist. A plan of action is needed that includes counseling or therapy for the youth and the family. The youth and the family need assistance in building self-esteem, problem-solving, and developing new and better ways to communicate. Treatment programs for young people who suffer from self-destructive thinking cannot be successful if they are short-term or individual-oriented in nature. They require professional intervention that meets the youth and their families with consistent respect, care, concern and interest (Peck, Farberow, & Litman, 1985).

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