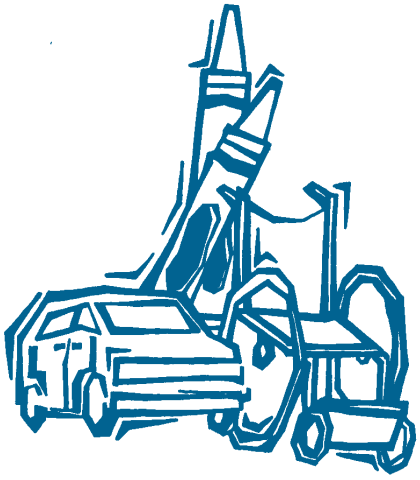

FAMILY

Preventing Youth and Adult Suicide no. 10.213

by R.J. Fetsch, C.L. Collins, and D. Whitney[1] (5/08)

Suicide is the leading cause of death by injury for youth and adults in Colorado, and more individuals die by suicide than by motor vehicle accidents. Suicide is the second-leading cause of death among children, teenagers, and young adults in Colorado, second only to motor-vehicle traffic related accidents, and the leading cause of death by injury for Coloradoans ages 35-74. (Colorado Violent Death Reporting System, 2007). Every year in the United States 250,000 youth attempt suicide. Of those in the 15 to 24 age group, 4,000 die per year (CDC, 2005). This means that every day close to 11 of our young people die by suicide in the U.S. It is known that children under 15 also think about, attempt and commit suicide (Gould, Shaffer, & Greenberg, 2003). 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 to 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). Seven 10- to 14-year-old and 51 15- to 19-year-old Coloradans took their own lives in 2005 (CDC, 2005). In the U.S., the Center for Disease Control's National Youth Risk Behavior Survey revealed that 19.3 percent of students in grades 9 to 12 reported seriously thinking about attempting suicide, 14.5 percent reported making a specific plan of how to attempt suicide, and 8.3 percent reported attempting suicide. In the same study, female students were more likely than male students to report suicidal ideation, making a suicide plan, and to have made a suicide attempt requiring medical attention, but the differences were not statistically significant (Apter & Wasserman, 2003).

The Rocky Mountain region has the highest suicide rate in the country. Colorado's suicide rate at 17.3/100,000 was over 1.5 times the national rate at 11.0/100,000 in 2004, which makes it 6th highest in the nation at roughly 720 deaths each year from suicide (Minino, Heron, Murphy, & Kochanek, 2007). The largest number of suicide deaths occurs among middle-aged men 35 to 44 years of age, but the highest rate of suicides in Colorado occurs among men 75 years of age and older (CDC, 2005). They are also the least likely to seek mental health counseling. 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 external cause of death on farms and ranches (T. Daniels, 8/22/2000 e-mail communication). Between 2000 and 2004, the external cause of death for one out of five Colorado ranchers and farmers was suicide (K. Bol, 10/20/2005 e-mail communication). Livestock and tractors were the second and third leading external causes of death in Colorado rural areas (T. Daniels, 8/22/2000 e-mail communication and Colorado Department of Public Health and Environment, 2005).

Quick Facts...

Seven 10- to 14-year-old and 51 15- to 19-year-old Coloradans took their own lives in 2005.

Each year approximately 720 Coloradans die by suicide.

Colorado counties with the highest suicide rates between 2001 and 2003 were: Sedgwick, Costilla, Gilpin, Saguache, Moffat, Las Animas, Clear Creek, Conejos, Rio Blanco, Archuleta, and Lincoln.

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

Colorado State University Extension

Table 1: Warning signs.

Verbal

"I wish I was 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."

(Bridge et al., 2006; Buzi et al., 2007; Field et al., 2001; Galaif et al., 2007; Gould et al., 2003; Stanard, 2000.)

Counties with the highest suicide death rates (per 100,000 population) between 2001 and 2003 are scattered throughout Colorado—Sedgwick (60.8), Costilla (53.6), Gilpin (47.7), Saguache (32.2), Moffat (30.1), Las Animas (29.4), Clear Creek (27.9), Conejos (27.7), Rio Blanco (27.7), Archuleta (27.6), and Lincoln (27.2). Counties with the lowest suicide rates between 2001 and 2003 include Summit (5.0), Prowers (7.0), Douglas (9.2), Yuma (10.1), Eagle (11.6), and Weld (11.7) Counties (Colorado Department of Public Health and Environment, 2005, pp. 184-185). These counties experienced recent rapid population growth and economic prosperity (Colorado Trust, 2002, p. 16).

The last three decades have seen stable suicide rates among adolescents aged 10-14. From the 1960's to 1988 there was a dramatic, threefold increase in suicide rates among ages 15-19 years, but since the mid 1990's, suicide rates have declined among 15-24 year olds (Gould et al., 2003). It is believed that the increase in adolescent suicides from 1960 to 1988 related 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). Although adolescent suicide rates have shown a slight decline, the reasons are mostly unknown; however, hypotheses have included the following: a restriction of the availability of lethal methods, an increase in anti-depressants prescribed to adolescents, and an increase in the prevalence of substance abuse among adolescents (Gould et al., 2003).

Reasons for Suicide

The primary reasons for not seeking professional help that were given by adults 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).

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, 1996). 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 (Stanard, 2000). 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 their problems.

Some of the reasons youth give for thinking of suicide as a solution to problems are: to make others feel sorry for them, 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, or to die (Diekstra, & Hawton, 1987).

Most experts believe 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. Depression is a very common warning sign. Not all depressed youth try to kill themselves. But the majority of youth who do attempt suicide experience depression.

Depression is the leading cause of suicide, suicide attempts, and suicidal thinking in youth (Galaif, Sussman, Newcomb, & Locke, 2007; Martin & Dixon, 1986; Stivers, 1988). Psychiatric disorders have been identified in 90 percent of teen suicide completions, and mood disorders such as depression are most commonly diagnosed. However, it is important to remember that some adolescents commit suicide without showing signs of depression and many depressed adolescents do not commit suicide (Berman, Jobes, & Silverman, 2006; Bridge, Goldstein, & Brent, 2006; Shaffer et al., 1996). 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 adolescents. Having the blues can be a normal experience when it does not 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. Risk factors for depression in adolescents that may also lead to suicide include the following: a history of abuse or neglect, persisting or escalating stressful life events, parental depression or intergenerational psychiatric illness, conduct disorder, poor family functioning or relations with parents, lack of healthy and satisfying peer relationships, school performance problems, and substance abuse (Bridge et al., 2006; Buzi, Weinman, & Smith, 2007; Field, Diego, & Sanders, 2001; Stanard, 2000).

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; Stanard, 2000).

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, or loss of energy (Martin & Dixon, 1986; Patros & Shamoo, 1989; Stanard, 2000).

Alcohol and other drug use can increase the risk of suicide, especially if used to escape pain (Galaif et al., 2007). 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 like 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 (Berman et al., 2006). 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 (Berman et al., 2006; Patros & Shamoo, 1989; Stanard, 2000).

There is no complete list of symptoms for any youth or adult. There is usually no single cause or one 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 or adult 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 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 person's life.
- Trust your own judgment.
- Tell parents, guardians, guidance counselors, partners, etc.
- Express your concerns to the person 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. Call 1-800-SUICIDE 24 x 7 for assistance and local resources.

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 person may say to you.
- Assume that the person will be all right left alone.
- Leave the means of suicide available.
- Assume because others become involved that the person no longer needs your help (Patros & Shamoo, 1989).

References

Apter, A., & Wasserman, D. (2003). Adolescent attempted suicide. From R. King & A. Apter (Eds.), *Suicide in Children and Adolescents* (63-85). Cambridge, United Kingdom: Cambridge University Press.

Berman, A. L., Jobes, D. A., & Silverman, M. M. (2006). *Adolescent suicide: Assessment and intervention* (2nd Ed.). Washington, DC: American Psychological Association.

Blumenthal, S. J., & Kupfer, D. J. (1988). Overview of early detection and treatment strategies for suicidal behavior in young people. *Journal of Youth and Adolescence*, *17(1)*, 1-23.

Bridge, J. A., Goldstein, T. R., & Brent, D. A. (2006). Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry*, *47*, 372-394.

Buzi, R. S., Weinman, M. L., & Smith, P. B. (2007). The relationship between adolescent depression and a history of sexual abuse. *Adolescence*, *42*, 679-688.

Centers for Disease Control and Prevention (CDC). (2005). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. National Center for Injury Prevention and Control. Retrieved February 14, 2008, from www.cdc.gov/ncipc/wisqars/default.htm.

Colorado Department of Public Health and Environment. (2005). *Injury in Colorado.* Retrieved February 16, 2008, from www.cdphe.state.co.us/pp/injepi/InjuryinColorado/injuryincolorado.html.

The Colorado Trust. (2002). *Suicide in Colorado.* Denver: Author.

Colorado Violent Death Reporting System. (2007). *Highlights from 2004-2006.* Retrieved February 20, 2008, from www.cdphe.state.co.us/pp/injepi/cvdrs/CVDRSoverviewhandout.pdf.

Diekstra, R. F. W., & Hawton, K. (1987). *Suicide in adolescents.* Boston: Martinus Nijhoff Publishers.

Field, T., Diego, M., & Sanders, C. (2001). Adolescent depression and risk factors. *Adolescence, 36,* 491-498.

Galaif, E. R., Sussman, S., Newcomb, M. D., & Locke, T. F. (2007). Suicidality, depression, and alcohol use among adolescents: A review of empirical findings. *International Journal of Adolescent Medicine and Health*, *19,* 27-35.

References (cont.)

Gould, M. S., Shaffer, D., & Greenberg, T. (2003). The epidemiology of youth suicide. From R. King & A. Apter (Eds.), *Suicide in Children and Adolescents* (1-40). Cambridge, United Kingdom: Cambridge University Press.

Martin, N. K., & Dixon, P. N. (1986, March). Adolescent suicide: Myths, recognition, and evaluation. *The School Counselor*, *31*(1), 75-82.

Minino, A. M., Heron, M. P., Murphy, S. L., & Kochanek, K. D. (2007). Deaths: Final data for 2004. *National Vital Statistics Reports*, *55* (19). Retrieved February 23, 2007, from www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_19.pdf.

Muuss. R. E. (1996). *Theories of adolescence* (6th ed.). New York: McGraw-Hill.

Patros, P. G., & Shamoo, T. K. (1989). *Depression and suicide in children and adolescence.* Boston: Allyn and Bacon.

Peck, M. L., Farberow, N. L., & Litman, R. E. (Eds.). (1985). *Youth suicide.* New York: Springer Publishing Company.

Shaffer, D., Gould, M. S., Fisher, P., Trautman, P., Moreau, D., Kleinman, M., & Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*, *53*, 339-348.

Stanard, R. P. (2000). Assessment and treatment of adolescent depression and suicidality. *Journal of Mental Health Counseling*, *22*, 204-217.

Stivers, C. (1988). Parent-adolescent communication and its relationship to adolescent depression and suicide proneness. *Adolescence*, *23(90),* 291-295.

The primary purpose of professional intervention is to assess the seriousness of the person'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. Currently, the most effective treatment for clinical depression is a combination of antidepressant medication and counseling. 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 and adults 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 person and their families with consistent respect, care, concern and interest (Peck, Farberow, & Litman, 1985).

Myths and Facts About Youth and Suicide

(from Berman et al., 2006; Martin & Dixon, 1986; Patros & Shamoo, 1989)

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 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.

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