SUICIDE AMONG ADOLESCENTS

by M. Basheer Ahmed, M.D.

Suicides among adolescents have increased almost three times in the last two decades [1] and it is now regarded as the second leading cause of death among teenagers. Between 2,500 and 3,000 United States teenagers are expected to kill themselves deliberately each year. During the past year, a small suburban community of Dallas lost six high school children through suicide within a period of a few months, and the series of suicides appear to be almost an epidemic. The fellow students cried, the teachers were frustrated, and the parents despaired greatly. Suicide is a tragedy which leaves scars an deepseated guilt in family members.

The highest rate of suicide occurs in achievement-oriented, upper-middle-class communities where you expect minimum social disturbances. Boys are more likely to be successful in their attempts to kill themselves than girls. Unfortunately, suicidal adolescents cannot always be detected until it is too late.

Although the most recent statistics suggest that trends toward higher adolescents suicide rate may not continue, overall rates, especially for the older adolescent male, have shown discouraging increase in recent years. Also discouraging is the evidence that pediatricians and family physicians who see teenagers are neither approached about suicidal problems nor do they ask about them [13].

Suicide is not an easy subject to discuss. It is a taboo topic. Most of us have great difficulty in understanding the diagnosis of adolescent suicide. The cultural, socioeconomic conditions, the media, the family expectations, all effect the most vulnerable individuals of our society — the adolescents. The increase in adolescent suicide rate is related to economic depression, social and family structure breakdown, and changing habits, e.g., drugs, alcohol, etc., which are harmful to health.

The real incident of suicide among adolescents may be much higher than what has been recorded. In spite of improvement in statistical reporting, the recording of death by suicide is always under-reported. Whenever there is doubt about the cause of death, for example, in case of accident or overdose, the cause in invariably recorded as accidental. It is estimated that over 50% of teenage automobile or motorcycle accidents are in fact resulted from suicidal behavior. The overwhelming tendency among authorities and parents is to disregard the liklihood of suicide whenever possible because of their own feelings of guilt. Of course, committing suicide is against religion and it is against the law in many states. All these factors affect negative reporting of death by suicide [2].

The overall death rate is fairly low in adolescents, but it is ironic to see an increase in suicide rate in adolescents. Several hypotheses are put forward to explain the relationship of increase in adolescent population and adolescent suicide. The increase in adolescent population resulted in increase in competition for the same number of positions in universities, sports teams, and jobs. Many adolescents fail to get good positions and do not receive appropriate support and guidance from school counselors or vocational counselors in time. As a result of this, those adolescents who fail to achieve their goals see themselves as failures and lose their self-esteem. The lonely and emotionally depressed adolescent may see most of his peers as functioning relatively well and this further lowers his already low and excessive vulnerable self-esteem with the consequences of hopelessness, resulting in a suicidal attempt, or suicide [3]. *Common clues to the potential suicide:* General distress signals may include aggressive, hostile, negativistic, passive behavior and verbal or nonverbal communication about death. It is a myth to believe that those who talk about suicide will never commit suicide. Expressions of desire to die, e.g., "life is not worth living" or "I cannot go on like this", are really the child's communication of a sense of hopelessness and cry for help. Sudden change in basic personality patterns and withdrawal from social contact are also seen in potentially suicidal adolescents. There may be a change in mood, loss of interest in activities, and withdrawal from friends. Disturbance in sleep and appetite may also be noted. Inability to concentrate and a decline in academic performance may be obvious prior to a suicidal act. Giving away of the possessions, for

example, camera or watch, is an ominous sign, giving warning of potential suicide.

Precipitating factors for suicide:

1. *Parental expectation.* Some parents totally neglect and others may develop high expectations of their children to achieve high status in academic and athletic performance. It places unrealistic expectations on the child and he does not get a chance to develop his sense of self. When the child fails to satisfy the parental wishes he develops poor self-concept, guilt, and ultimately suicidal ideas.
2. *Sense of rejection.* Suicide represents an attempt to escape feelings of not being wanted. These feelings might be valid as a child may experience blatant rejection or physical and emotional abandonment by parents [7]. The suicidal child presumed the parental wish, conscious or unconscious, spoken or unspoken, as the desire to get rid of him [4]. Often children communicate their emotional traumatic experiences to parents. "You will be sorry when I am dead." When parents do not respond in a supportive manner children develop acute feelings of rejection.
3. *Conflict with mother.* Conflict with mother as the key person often forms the background for suicidal acts. In other cases the child may identify with mother's depression and may feel helplessly unable to escape from the painful situation [5].
4. *Parental suicidal behavior.* Suicidal adolescents come from families where history of parental suicidal behavior is present. Parents of suicidal children were found to be significantly more depressed and displayed more suicidal behavior than did the parents of similar groups of nonsuicidal children [6].
5. *Family background.* Problematic family communication patterns and the degree of psychopathology in the family will promote stress that contributes to suicidal behavior among children. Presence of stress manifests itself in increased rates of drug abuse, alcoholism, depression, and suicide. Many families of suicidal children had evidence of economic stress. Parents' preoccupied with economic concerns may be less able to pay attention to the psychological stresses in their children. Due to financial distress many mothers work full-time and a full-time working mother may be less available at the time her child needs support and guidance. Family disintegration plays a significant role in emotional disturbance of children and suicidal behavior. Absence of one or both biological parents may be found among suicidal adolescents. Adolescents who attempt suicide may have difficulty reaching out to other family members for help and utilizing the help when it is offered. Because of severe distress and disorganizing factors in the family these individuals may develop characterological limitations that prevent them from being helped by others. [8].
6. *Television and children.* Children witness several thousand violent, bloody, and brutal death scenes on television during childhood and adolescence. During their formative years these children are indoctrinated to violence and death. They learn to deal with anger and frustration toward others or one's self in an inappropriate manner [9].
7. *Drugs and suicide.* There has been a marked increase in incidents of drug and alcohol abuse in adolescents. Some adolescents face extreme difficulty in overcoming the dependence and think about suicide as the only alternative.
8. *Unwanted pregnancy.* In spite of use of contraceptives the unwanted pregnancies in adolescents have risen considerably and this leads to conflict with parents and society. Some adolescents are unable to cope with the distress caused by this conflict and turn to suicide.

Thus, the family disintegration, broken romance, alcohol and drug abuse, unwanted pregnancy, major confrontation with parents, despair, and detachment all are contributing factors for suicidal behavior.

9. *Depression and suicide.* For a long time depression in adolescents was regarded as developmental turmoil and ego recognition. It is recognized that many of these adolescents, in fact, may be suffering from depression. It should also be noted that depression in adolescents may be presented as acting-out behavior, school phobia, or anorexia. The presenting symptoms may mask the underlying depression. Until recently primary depression was considered uncommon in teenagers. The reason for this was accounted for largely by misdiagnosis. In the majority of adolescents who are diagnosed as

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suffering from major depression one sees the reason for decline in school performance, impaired concentration, and the loss of interest in previously pleasurable activities, as very common presenting complaints. Adolescents with depression as defined by adult criteria is not substantially different phenomenologically from their adult counterpart. Depression is present in a substantial number of patients with suicidal behavior. However, half of the teenagers who were admitted making suicidal attempts were not depressed and these attempts were unpredicted. Persistent suicidal ideation is usually an indication for depression and the adolescent hospitalized for suicidal attempts must be thoroughly evaluated for the presence of depression [10].

Prevention and Management of Suicidal Behavior.

1. Identification of early signs of distress, depression, and potential suicide is an important step in prevention of suicide.
2. Teachers, school guidance counselors, and clergymen all must receive special training in identifying the early signs of emotional distress and learn to pay attention to depressed patients and recognize the potential for suicide.
3. Parents, family members, and friends must be informed through public education about recognizing:
   a. Change in personality, mood, and behavior.
   b. Signs of alienation, excessive anxiety, and distess.
4. It is essential that parents, teachers, and physicians must face unpleasant situations and hear a person's attempt to communicate his distress. Listening, paying attention, and taking interest in the disturbed individual is essential.
5. Youngsters should never be challanged to act on their suicidal thoughts. Whenever possible the suicidal feelings must be discussed openly although it is a difficult subject to discuss even for professionals.
6. Family physicians and emergency room physicians are usually the first to see a patient with suicidal attempt. Management of patient's physical condition is the first priority. Hospitalization is necessary for patients with serious suicidal attempts. Whether a patient with suicidal attempt is hospitalized or only receives emergency medical care, he must be referred for a thorough psychiatric evaluation [11]. On many occasions the relatives of a patient with a minor suicidal attempt may contact the family physician for assessment of such a patient. If the family physician believes that there is no immediate danger to the patient's health, he may decide not to refer the patient to the hospital for further management. In these circumstances it is advisable that patient and family be referred for psychiatric consultation.
7. Training of all physicians in the assessment of suicidal risk is important since most known suicides have recently seen a physician before killing themselves.
8. Physicians must not show negative attitudes toward the adolescent with suicidal behaviors. They must show a more sympathetic understanding of these patients crying for help.
9. All medical students must receive special instructions in examination and evaluation of adolescents with suicidal attempts. They must

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develop a positive attitude and have a capacity to hear the distress and despair of life's situations. Exposing them to evaluation of these patients under supervision will ultimately help them in developing this competence. Similarly, newly qualified physicians must undergo inservice training for identifying the potentially suicidal patients and develop a technique to help the patients under distress. They should be expected to provide care for these patients with equal diligence.

10. In case of crisis intervention in acutely suicidal patients, one should ask the reason for the death wish and show appreciation for seriousness of the situation. Non-judgmental listening and responding are essential. Always provide them assistance in determining alternative solutions to problems perceived by the suicidal adolescent.

Conclusion. Suicidal behavior among young adults increased dramatically in the last three decades. In spite of improved reporting of deaths, these suicides are underreported due to various social and psychological reasons. Suicidal behavior in adolescents is a serious symptom worthy of great clinical concern. Children are becoming more dependent upon parents as extended family systems, organized neighborhoods, and churches disintegrate and lose their influence. With the high divorce rate, many children lose contact with at least one of the parents. Life for teenagers is becoming more impersonal and lonely. Important factors for consideration of suicidal behavior are depression, family interaction, ego function, and concept of death. The act of suicide reflects the despair and death as an answer to their conflicting anxieties. Every youngster who attempts suicide or expresses desire of suicide should have a through psychiatric evaluation. Every child who manifests any behavior disturbance should be assessed for early warning signs of suicidal potential. Educating clinicians about suicidal behavior in children will aid in improving early evaluation and intervention. In addition to hospitalization, pharmacological treatment and psychotherapy, the clinician must aim at enhancing communications between parents and the child. A comprehensive management plan for suicidal children includes school consultation, academic remediation, and involvement of teachers, clergymen, parents, educators, and school counselors, who need to be trained to tune into the needs of a child in distress [12]. A school counseling program should be available to help a troubled adolescent. Every parent needs to become more in touch with the specialized needs of the child going through adolescence and provide care and affection. All medical students, health professionals in training, and young physicians must receive special training in recognizing the potential for suicidal behavior and early signals of distress and despair in adolescents. All family physicians and emergency room physicians, must be trained to do comprehensive evaluation, physical as well as psychological, for young adolescents with suicidal attempts. Whenever it is possible, and in fact, almost all cases should be referred for a comprehensive psychiatric evaluation whether they are hospitalized or not hospitalized. Inpatient treatment, pharmacological treatment, individual and family therapy are all to be considered for adolescent suicidal attempts. Individual psychotherapy and family therapy must focus toward: 1) Better communication between parents and child, 2) Development of bond between parents and child, 3) Development of sense of attachment and trust. Unfortunately, we have not been able to develop effective aftercare programs to prevent recurring suicidal behavior. With the development of improved psychiatric care and better communication

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LEGAL ABSTRACTS, *cont'd*

MD Loses Suit Against Telephone Company For Omissions In The Yellow Pages Directory . . . A telephone company was not liable for compensatory or punitive damages to a physician whose listing was omitted from two lists in the company's Yellow Pages directory, the Florida Supreme Court ruled.

The physician filed suit against the telephone company for omitting his name, address and telephone number from the Yellow Pages. The basis of the complaint was the allegation that the company had agreed to list the physician as a physician and as a specialist in obstetrics and gynecology in the Yellow Pages, and that his listing was omitted from such lists for two consecutive years: 1973-1974 and 1974-1975. The physician alleged that he had communicated with the company on numerous times after the first omission and had been assured that the proper listing would be published. The physician sought compensatory damages for the two omissions. He also sought punitive damages because, he claimed, the second omission constituted gross negligence.

A trial court directed a verdict in favor on the telephone company on the issues of compensatory and punitive damages. The appellate court reversed the decision as to the punitive damages claim and held that the issue of punitive damages should have gone to the jury. The issue of compensatory damages was not appealed by the physician.

On appeal to the Supreme Court, the court found for the telephone company and reinstated the trial court's directed verdict for the company on the issue of punitive damages. The court said that the company made special efforts to ensure that the physician's listing would not be omitted a second time. That the efforts failed did not establish gross negligence, the court said. — *Southern Bell Telephone and Telegraph Company v. Hanft,* 436 So.2d 40 (Fla.Sup.Ct., June 16, 1983; rehearing denied, Sept. 8, 1983)

Editor's Note: An earlier decision in this case was reported in THE CITATION, Vol. 44, No. 6, p. 61.

Cocktail Party Not Allowed As Business Expense . . . An oral surgeon was not entitled to a business entertainment expense deduction for the cost of a cocktail party, the Tax Court ruled. The party was attended by 200 persons, primarily physicians, dentists, and their spouses. The court said the party was not directly related to the conduct of his practice and was merely to create goodwill among referring physicians and dentists. — *Gardner v. Commissioner,* T. C. Memo. 1983-171 (March 30, 1983)

SUICIDE, *cont'd*

bond between parents and children it is expected that the loss of life can be preserved.

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