ADOLESCENT SUICIDE: PREVENTIVE CONSIDERATIONS

by Dora Black

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Suicide in prepubertal children is rare, and the rates appear stable over time.[1-3] By contrast, the rates of suicide and attempted suicide in older teenagers have increased appreciably during the past 30 years in most countries where accurate statistics are kept, whereas in older people they have remained stable or declined.[3 4] In 1984 in England and Wales 112 people under 20 killed themselves.[5] In Japan, with roughly twice the population, 572 under 19 year olds killed themselves.[6] In the United States suicide is now the third most common cause of death in 15-24 year old white young men.[7]

In most countries suicides by men outnumber those by women by at least 2:1, although attempted suicide is far commoner in girls. The methods used by boys and men are more violent (firearms, jumping from high places, and hanging) and more likely to result in death. Women and girls favour overdosing, where resuscitation is more likely.[3] The two groups, suicide and attempted suicide, vary in many ways but 46% of young suicides (under 14) had made threats or attempts before the act,[1] and in the follow up study of youngsters aged 10-20 who had attempted suicide 10% of the boys and 3% of the girls eventually killed themselves, usually within two years.[8] Repetition rates in a later study were much lower (0.24%)[9] probably because the earlier one included all forms of attempted suicide.

The impact on those most closely connected with a young person who kills himself are profound. Family, teachers, friends, and workmates experience guilt and stigma. Reactions of denial and blame are common. Mourning may be more difficult for the family because friends avoid talking to them about such deaths.[3]

If we are to prevent or reduce the number of adolescent suicides we must understand the causes. The problems of studying causation when of necessity the study must be retrospective have been summarised by Hawton.[3] Among adults committing suicide 90% have psychiatric disorders, especially depression and schizophrenia.[10] The rate in young people is probably less than 50% but there is often a family history of both psychiatric disorder and suicidal behaviour.[1 11] There may therefore be a genetic predisposition to depression or other psychiatric disorders. In addition the behaviour (taking pills, attempting suicide) may be imitated. Finally, living with a mentally ill parent, especially a single parent, may be intolerable. Most young people who kill themselves have high levels of family disruption and in addition may have suffered physical abuse or possibly sexual abuse. A recent study using controls has come from Boston where 159 youngsters attempting suicide were carefully matched and the registry of the department of social services searched for the names in both groups.[12] Prior contact with social services was three to six times more likely for probands of both sexes than controls. Most of these young people would have experienced child physical abuse or neglect.

A follow up study of 201 families in which intrafamilial sexual abuse had been substantiated found that 11 had experienced suicidal attempts within 2½ years, in most cases by the daughter-victim.[13] There was no control group. Since boys more commonly kill themselves than girls, sexual abuse is less likely to be a major factor in adolescent suicide as opposed to attempted suicide.

In Japan and elsewhere educational pressures may lead young people to experience hopelessness and lowered self esteem when they fail. Possibly teachers and schoolmates may increase the sense of isolation.[6] Finally, young people may be unable to establish themselves in work, love, or living apart from their family and this may heighten the sense of failure. This may account for the high suicide rate in young married Hindu women in Fiji.[14] Probably many of these factors will interact to produce the final suicidal behaviour.

What can doctors and other health professionals contribute to the primary prevention of suicide in young people? Probably their most important contribution is to recognise the early signs of mental illness, especially depression and schizophrenia. Depression may present with school failure after normal achievement, hyprochondriasis, or social withdrawal more often than with complaints of depression or anxiety by the youngster. If in addition the family background is disturbed, there is a family history of psychiatric illness, or child abuse is suspected or known then referral for specialist help may avert tragedy. The fact that prepubertal children and black American adolescents, both of whom may have high levels of family and social stresses, have lower suicide rates points to the possibility that protective factors may be operating.[2]

Secondary prevention implies the prevention of subsequent, possibly fatal, suicidal attempts in youngsters after their first attempt. This requires the energetic, persistent, and effective treatment of all youngsters attempting suicide.[3 15 16] If they are living with their families the latter will need to be included in treatment. Although family therapy seems an obvious choice, no treatments have been adequately evaluated in this age group. In my own practice most young people who have taken an overdose are given a card enabling them to readmit themselves to the paediatric ward without question. This approach awaits evaluation but so far has been used responsibly.

Finally, tertiary prevention implies the prevention of avoidable handicap in the members of the family and wider network of a young person who commits suicide. Probably the normal techniques of bereavement counselling are needed here, and particularly when siblings are present, but professional help may be needed to prevent morbid grief reactions in the survivors.[17 18]

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1 Shaffer D. Suicide in childhood and early adolescence. *J. Child Psychol Psychiatry* 1974; **15**: 275-91.
2 Shaffer D; Fisher P. The epidemiology of suicide in children and young adolescents. *J. Am Acad Child Psychiatry* 1981; **20**: 545-65.
3 Hawton K. *Suicide and attempted suicide among children and adolescents.* London: Sage, 1986.
4 McClure GMG. Recent trends in suicide amongst the young. *Br J Psychiatry* 1984; **144**: 134-8.
5 Office of Population, Censuses and Surveys. *Mortality statistics.* London: HMSO, 1984.
6 Boseley S. Epitaph for Hirofumi. *Guardian* 1986 Mar 5: 21 (col. 2).
7 Holinger PC. Adolescent suicide: an epidemiological study of recent trends. *Am J Psychiatry* 1978: **135**: 754-6.
8 Otto U. Suicidal acts by children and adolescents. A follow-up study. *Acta Psychiatr Scand (Suppl)* 1972; **233**: 5-23.
9 Goldacre M; Hawton K. Repetition of self-poisoning and subsequent death in adolescents who take overdoses. *Br J Psychiatry* 1975; **146**: 395-8.
10 Barraclough B; Bunch J; Nelson B; Sainsbury P. One hundred cases of suicide: Clinical aspects. *Br J Psychiatry* 1974; **25**: 355-73.
11 Garfinkel BD; Golombek H. Suicidal behaviour in adolescence. In Golombek H; Garfinkel BD, eds. *The adolescent and mood disturbance.* New York: International University Press, 1983.
12 Deykin EY, Alpert JJ, McNamara JJ. A pilot study on the effect of exposure to child abuse or neglect on adolescent suicidal behaviour. *Am J Psychiatry* 1985; **142**: 1299-303.
13 Goodwin J. *Sexual abuse: incest victims and their families.* Massachusetts: John Wright PSG Inc, 1982: 110-3.
14 Haynes RH. Suicide in Fiji: a preliminary study. *Br J Psychiatry* 1984; **145**: 433-8.
15 Taylor E; Stansfield SA. Children who poison themselves II. *Br J Psychiatry* 1984; **145**: 127-35.
16 Royal College of Psychiatrists. The management of parasuicide in young people under 16. *Bulletin of the Royal College of Psychiatrists* 1982; **6**: 182-5.

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REVIEWS



LOSS—AN INVITATION TO GROW
Jean C. Grigor. Pub. Arthur James. 1986. £5.95.

Jean Grigor has deep and wide experience of helping and counselling. She trained and worked as a teacher and as a deaconess of the Church of Scotland, and after a spell in Australia she returned home to become Assistant Director of Counselling Development for the Church. The fruits of her experience are now offered to us in this book which is described as a "workbook, specially suited to group study . . ."

In the book she builds on Spiegel's outline of the grief process, and she gives useful brief chapters on shock, control, regression and adaptation. But she takes the novel way of weaving the stages of grief into a pattern which includes reflection on her own experience along with insights gleaned from others whom she has helped.

There are useful chapters on grieving children, anger, guilt and our need for ritual. The comments on ritual are especially helpful and will counter any thoughts about 'mere ritual'—for, as we know, an outward act can be a most important vehicle for the acceptance of and expression of our deep feelings. But, rightly, the larger part of her book is concerned with the inner pain of grief and how we might, in Caplan's words, "psychologically bury the dead."

Sensibly, too, she considers how we react not just to death but to any of life's major changes—e.g. marriage or the birth of a child—pointing out that each change is a unique blend of loss and gain.

The book can of course be read by the individual but Jean Grigor would perhaps feel rewarded if people used it as a workbook for group study, and for this purpose she includes many exercises which can be used as they stand or adapted to particular circumstances.

No book can do the work of grieving for us but the best point us in the right direction. Here is such a book—a useful tool for any who are involved in bereavement care, and one which reminds us that any loss is truly an invitation to grow.

DEREK HALEY
Chaplain, Gartnavel Royal Hospital, Glasgow

'I CAN'T FACE TOMORROW'
by Norman Keir
Help for those troubled by thoughts of suicide
Foreword by Monica Dickens. Pub. Thorsons, Wellingborough, Northants (1986) in the 'Life Crisis' Series. £4.99.

Norman Keir, an experienced Samaritan counsellor, states that he has written his book with three specific groups of readers in mind; those generally or professionally interested in the subject of suicide, those with suicidal urges and those bereaved by suicide.

Belonging to the first category I found it rich in statistical evidence, history, ideas and good common sense. Underlying a serious approach is a wealth of quotations which range from Voltaire: 'The man who, in a fit of melancholy, kills himself today, would have wished to live had he waited a week', to Brian Clark's 'Whose life is it anyway'?

Apart from Alvarez's 'The Savage God', few writers have attempted to draw together the complex themes so often surrounding investigation into suicidal deaths. It is a hard subject to focus upon. Durkheim and Halbwachs presented the wide-angle view of man in society, individual case studies give close-up shots, psychiatrists, moralists and philosophers all contribute useful information to those who are involved with caring for the potential suicide or bereaved by such a death. It is a pleasure to discover a book which contains a breadth of focus but also takes time to stop and define the basic terms used in its discussion, such as psychosis, neurosis and parasuicide.

The penultimate chapter deals with the Samaritans and their approach to counselling and to those who turn to them for help, and the book ends with a useful further reading list with the warning given that the 'spirit should have more than an undiluted diet of books on the darker side of life'.

Keir has ensured that although serious his book is in no way dark. I would have liked a larger section on bereavement and feel that the book is more helpful to carers than the suicidal themselves—those who 'can't face tomorrow', or to those who are left to face tomorrow after a death by suicide. However, I welcome its arrival and recommend it as a useful source of information and a thoroughly 'good read'.

SUSAN WALLBANK
Cruse Counsellor

SURVIVAL GUIDE FOR WIDOWS
June Hemer & Ann Stanyer. Age Concern, 1986: £3.50 inc. p & p from Age Concern, 60 Pitcairn Road, Mitcham CR4 3LL, or from Cruse House, 126 Sheen Road, Richmond TW9 1UR.

I welcome the collaboration of the National Association of Widows, Cruse, Age Concern and Royal Life Insurance Ltd. in producing this practical and sensitive book. The immediate problems following any bereavement are formidable. They are now more complicated because of changes arising from the Social Security Act 1986, which are being brought into effect at different dates in Britain.

Ideally, survival guides for widows and widowers should be read soon after marriage. This is not morbid. In the usual course of life one or other is going to be left alone. Wills should be made early and not left to old age, especially as violent deaths from road and air crashes increase. I know from experience that intestacy creates a misery of uncertainty and delay.

Both should know where birth certificates and the marriage certificate are kept. I didn't, and a kind friend had to go to Somerset House to get copies.

In a truly sharing partnership there should be fewer widows who don't know how much the mortgage is or how to change a plug—and fewer widowers who can't cook or sew on a button. Too many married couples still think that they are coupled in all things ("we always did everything together" syndrome). I often got away from my husband because I couldn't play chess and he didn't like gardening. Keeping one's own interests—and nowadays more often one's job—builds bridges out of the house and diminishes total dependence.

But this book has to take care of situations after bereavement. Each of us has to find our own way. For many it is not a question of getting over the hole in life, but of finding a path round it.

Widows are not a stereotype and advice about how to help must vary. Some need the privacy of grief and others the solace of helpful company. Most do not want experts to point out the need to be glad of what has been, rather than to complain about what is. We know about that. I find one antidote to self-pity is the real realisation of the number of women of my generation who are old and alone because their bright young loves were killed in the war before the benison of marriage: no children, no pensions.

Today there are increasing numbers of unmarried couples—and there will be more. This has to be faced because bereavement of a lover can be more intolerable than a husband. Somehow it is not so respectable, nor so benefited nor comforted. Even the unwelcome status of widowhood is denied.

But, whatever the circumstances of bereavement, this wise book will be of help to many. Not of comfort, for there is none.

LENA JEGER
Patron of Cruse

AFTER STILLBIRTH AND NEONATAL DEATH
What Happens Next. Pub. SANDS, The Stillbirth & Neonatal Death Society, Argyle House, 29-31 Euston Road, London NW1 2SD. Price £2.50 inc. p & p.

When a baby dies around the time of birth, the parents can be overwhelmed by the decisions to be made at such a difficult time. Yet those decisions may have far-reaching effects and can strongly influence the process of grieving.

Helping bereaved parents understand the formalities and choices available has proved difficult for health care professionals. Because of the variety of disciplines involved—funeral directors, cemetery and crematoria management, the church and hospital administration—information has, until now, been fragmented.

In response to the need for concise and detailed guide-lines, SANDS has produced an information pack for health care professionals. In thumb-indexed format, the book explains the arrangements and procedures which are necessary following a baby's death. It provides a compact reference with 'fill-in' sections to store local information specific to each hospital or locality.

The book is accompanied by a supply of leaflets written specifically for parents: **'After the death or stillbirth of your baby—what has to be done?'** Both the book and leaflet deal clearly and comprehensively with the practicalities of registration, autopsy, funeral arrangements and memorials, and will prove an invaluable aid to those working in this sensitive area.

GLYNIS FLETCHER
Secretary, Stratford-on-Avon Branch
National Childbirth Trust

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17 Parkes CM. Bereavement counselling: does it work? *Br Med J* 1980; 281: 3-6.
18 Black D, Urbanowicz MA. Bereaved children: family intervention. In: Stevenson J, ed. *Recent Research in Developmental Psychopathology*. Oxford: Pergammon Press, 1984.