Teenage suicide

American adolescents and young adults are killing themselves in record numbers. In less than three decades, the suicide rate of 15 to 24 year olds has tripled and is expected to increase further. Pre-adolescent youngsters also have been committing suicide in increasing numbers.[1] Rosenthal and Rosenthal[2] claim that even preschool children (between 2½ and 5 years old) show suicidal behavior. An estimated 5,400 young people take their own lives each year. Among the white males in this group, only accidents claim more lives than suicide. However, many accidents, particularly vehicular deaths, may be disguised suicides. Accidents, suicides, and homocides account for three-quarters of all deaths of adolescents and young adults. It is ironic that during the past three decades, when American medicine has provided the most technologically advanced health care, the mortality rate of American youth has actually increased 11%.[3]

Those in the fields of law, religion, and medicine all agree that suicide must be prevented. Yet, prevention has been a problem. In most states, it is a crime to help others commit suicide. Most life insurance policies do not honor suicide claims. All established religions dissuade their followers from suicide. American medical thought holds that suicide is an irrational act of a troubled mind that can and must be treated. Despite all efforts, teenage suicide is increasing, while other age groups have shown a decline in the rate of purposeful self-inflicted injury.

Teenage suicide leaves survivors with feelings of grief, rage at being deserted, and guilt at having somehow failed the victim. When suicides occur in clusters and seem "contagious," as in many suburban communities around the country in recent years, the neighborhood residents are frequently in panic and are scurrying for the answers or antidotes to prevent recurrences. Various community efforts to curtail the sudden upsurge of teenage suicides, such as 24-hour hotlines, seminars, and discussion groups, do not necessarily reduce the actual suicide rate, even though the programs offer opportunities for the troubled adolescents to receive help.

Suicide is viewed as a chronic deficiency disorder—a deficiency of social connections.[3] Our modern society has undergone tumultuous changes in the ways we relate to each other. Households with teenagers frequently behave centrifugally—everyone moving away from one another. Also, family members are frequently all too hurried to understand what each means to say to the other.

Many teenage suicides seem impulsive or are backfired adventures. However, most suicidally depressed adolescents think about their own deaths for some time before the ambivalent conflict between despair and hope reaches the existential crisis point. More often than not, they actually voice their wish to die to someone who might not only listen to but also empathize with their agony. In an oft-quoted study done in southern California, most of the suicidal teenagers visited their primary physicians with a functional complaint within two months prior to their suicidal attempt.[4] The clinicians who were sensitive to the inner turmoils of the adolescents might have understood the real purpose of the visit. Here, healing begins with understanding.

Suicide must be evaluated in terms of its lethality of intent and intentionality, just as congestive heart failure or diabetes mellitus is evaluated in terms of its severity. Some physicians do not want to adulterate an innocent mind by bringing up the subject of suicide with the teenager, although the teenagers will most certainly talk about their suicidal thoughts if asked. Teenagers need to be asked whether they feel suicidal and whether they have had past thoughts of and attempts at suicide. Shaffer[5] stated that 14 (46%)

of his 30 suicidal subjects had previously "discussed, threatened, or attempted suicide."

Some suicide attempts are referred to as "gestures." When lethality is apparently low and perturbation is high, the suicidal act is viewed as a "cry for help" or as a "gesture." I think such descriptors are often hostile and destructive to the patient who has already been diminished in the eyes of others, including the physicians, by having failed to "control" his or her own life and death. An attempt is genuine, no matter how poorly it is conceived and carried out.

A suicide attempt is a medical emergency for which the state statutes specify intervention and protection for the person. The suicidal teenager must be allowed time and given support at the critical moment of emergency when he or she could either live or die.

We train the young physicians to resuscitate the dying congestive heart failure patients. We should also train them to breathe life into the dying "broken-hearted" patients, young or old.

DAVID S. RUE, M.D.
Department of Child and Adolescent Psychiatry
The Cleveland Clinic Foundation
9500 Euclid Ave.
Cleveland OH 44106

References

1. Pfeffer CR. Suicidal behavior of children: a review with implications for research and practice. Am J Psychiatry 1981; **138**:154–159.
2. Rosenthal PA, Rosenthal S. Suicidal behavior by preschool children. Am J Psychiatry 1984; **141**:520–525.
3. Eisenberg L. Adolescent suicide: on taking arms against a sea of troubles. Pediatrics 1980; **66**:315–320.
4. Teicher JD. Children who choose death. Emerg Med 1975; **7**;136–142.
5. Shaffer D. Suicide in childhood and early adolescence. J Child Psychol Psychiatry 1974; **15**:275–291.