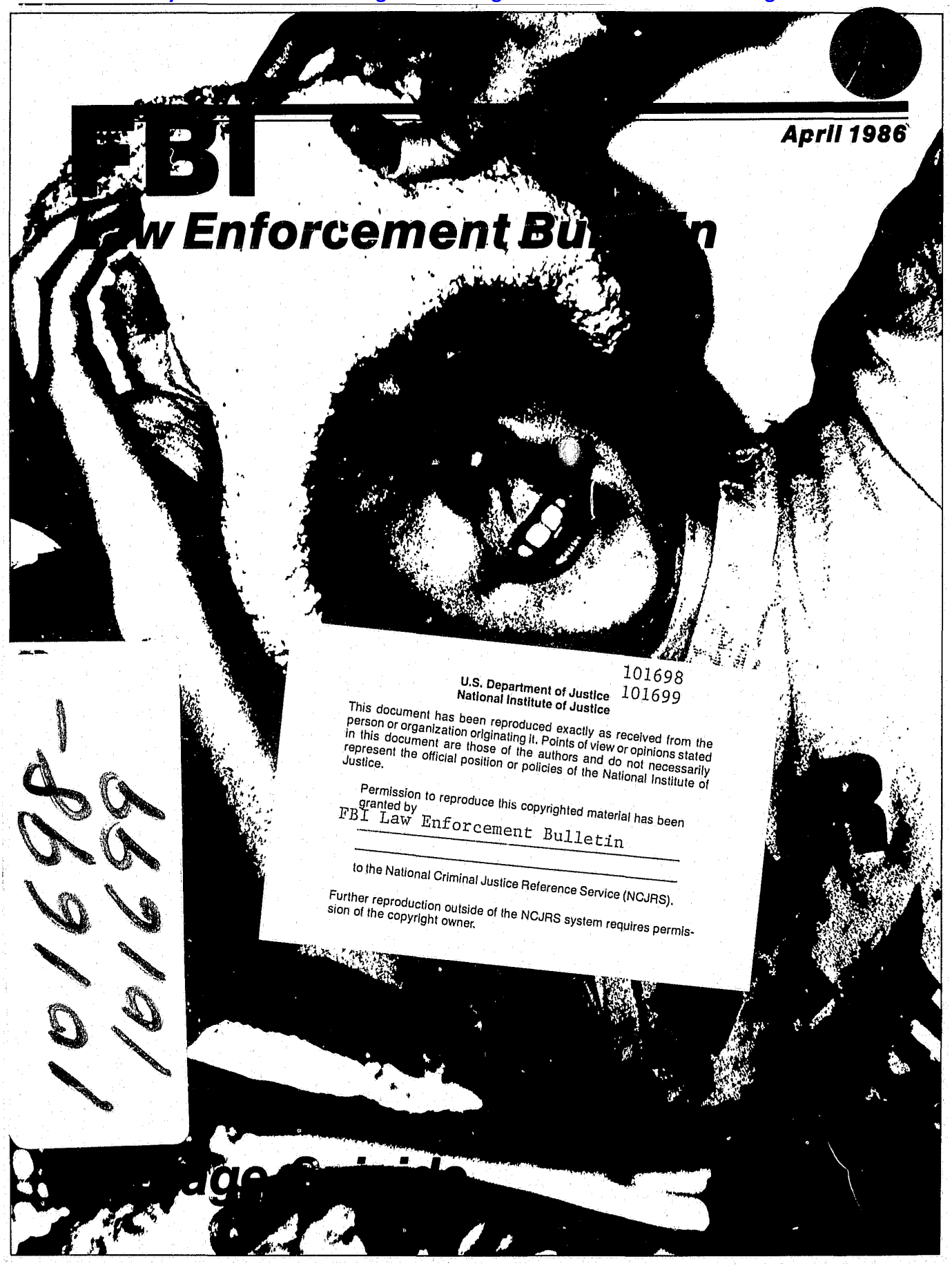

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Contents

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The Cover:
Increased public and national attention is needed to combat the problem of teenage suicide. See article p. 16.

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Teenage Suicide
An American Tragedy

"Identifying a suicidal youngster and then connecting him with appropriate treatment and rehabilitation programs represents a major way of saving lives."

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During the past 20 years, the suicide rate has tripled among people aged 15 to 24. Suicide has become the third leading cause of death for this age group, with over 5,000 young people killing themselves in 1984 alone. As many as 500,000 other youths attempt suicide, while probably a million, or more, children think about committing suicide.

This article is an attempt to look at youth suicide from different points of view, with the goal of assisting police officers deal with the problem. Identifying a suicidal youngster and then connecting him with appropriate treatment and rehabilitation programs represents a major way of saving lives. Law enforcement officers must be aware and alert to identify possible suicidal juveniles.

Authorities at the National Institute of Mental Health recently reported that an American teenager commits suicide every 90 minutes. Although the American Psychiatric Association recently reported that the incidence of suicide among young people had reached a temporary plateau, it has risen quite dramatically—by 300 percent over the past 30 years. The suicide rate for teenagers rose 41 percent between 1970 and 1980.[1]

These statistics are probably conservative as youthful suicides tend to be underrecorded because survivors tend to opt for a more acceptable reason of death for social, legal, religious, and economic reasons. Who are the young people behind these statistics?

It is impossible to draw a single, simple portrait of the typical young suicide victim. Children from all socioeconomic and ethnic groups have committed suicide. Family problems, loneliness, depression, and desperation appear to be important factors. Most frightening to authorities is the fact that young people may get the idea to kill themselves from reading or hearing about other suicide victims. Some had parents who were suicidal or who had committed suicide. Their example may have taught the child this terrible form of coping. Most have an inordinate amount of stress, a broken home by divorce, remarriage, or marital discord, and many are the firstborn child. Observation has shown that poor communication within the family unit, a sense of isolation, feelings of rejection, and lack of self-esteem are also factors in teenage suicide. Not one of these factors brings about suicidal behavior, but when they occur in combination, they are very dangerous.

Many suicidal young people have the inability or lack of opportunity to express their unhappiness, frustration, or failure. They find that their efforts to express their feelings are either totally unacceptable to their parents, ignored, or met by defensive hostility. This response often drives the child into further isolation, reinforcing the belief of something being terribly wrong.

"Some youths ... lack coping mechanisms for the enormous psychological stresses they face."

The increasing use, and abuse, of alcohol by teenagers has added another element to the problem.[2] Drinking is a big factor in suicides. Alcohol causes depression, affects one's judgment, and may pave the way for a suicidal attempt.

Many teenagers contemplate suicide; some attempt it; an alarming number succeed in taking their own lives. Yet, many of these depressed, desperate youngsters do not really want to die; they simply want to escape their problems.

Adolescence itself is a particularly precarious, comparatively short transitional period in which a child is expected to be transformed into an adult. Change, by its nature, means instability. Adolescence is also a period of forming, however imperfectly, self-esteem, the sense of individuality, the values, and the coping skills that one must depend on in adulthood. It is an enormous task even in the most supportive and stable environments. It is not accomplished in a formal, rational, structured fashion, but rather piecemeal, intuitively, instinctively, and unconsciously. In our modern society, in which everything from cultural mores to the cohesiveness of the basic family unit is often riddled by instability, it is little wonder that an adolescent's struggle can sometimes end disastrously.[3]

Authorities offer different theories about why teenagers end their lives. In some cases, a teenager may be driven by a precipitating event or "trigger incident" which might include an argument at home, a breakup of a relationship, not making a team, not getting a date, not passing an exam, or other such events. These are perceived as insurmountable failures and embarrassments.[4] Adolescents lack the adaptive skills or experience an adult might employ in handling such setbacks. They suffer from tunnel vision; all they see is darkness. They do not understand that there is light at the end of the tunnel.[5]

During adolescence, the mind itself undergoes changes that enable it to take on new ways of thinking and dealing with the world. In changing from a child to an adult, the adolescent must come up with totally new definitions of who he is, what his talents are, what the world is, how it stands in relation to him, and how to relate with it.[6] Some youths have never learned to withstand disappointment and have not had enough experience with life to understand that problems will be resolved. In summary, they lack coping mechanisms for the enormous psychological stresses they face.[7]

Some Psychodynamic Observations

Certain specific, clear-cut differences have been found between the committed-suicide group and the other groups of suicidal adolescents. Greater frequency of psychiatric hospitalization, combined with a higher rating of emotional disturbance and fewer prior suicide attempts, marked the history.

There is some evidence that the adolescent who commits suicide has a greater predisposition toward self-destruction, and therefore, requires less overt stress than his colleagues to initiate the suicide act. This evidence was confirmed in some degree by the fact that the loss or threatened loss of a loved one operates less often as a precipitating stress or "trigger" among those in the committed-suicide group than it did on the attempts of those in the suicidal groups. Stress was reported to be higher among people who attempted suicide. The reaction was to communicate their suicidal intent openly, i.e., verbally or behaviorally, in order to let others know of the psychological pain they were experiencing, and thus ultimately, to reduce the stress they were feeling.

Categories of Youth Suicide

The Loner

This personality type begins to emerge at age 14 or 15 and has been described as fitting a clear-cut symptom pattern. Characteristics associated with this kind of person center around loneliness, isolation, lack of friends, and poor interpersonal communication with peers and parents. Most often, youngsters who are described as "loners" come from intact families, though it appears that these parents have difficulty with their image of themselves as parents and are constantly concerned about making mistakes and not being good parents. They interpret the child's complaints about problems, unhappiness, or general life difficulties as a statement of their lack of competence, and therefore, in a defensive gesture, will often insist to the child that he really is not unhappy and has nothing to complain about. In these families, the child usually learns at an early age that what he thinks of himself and what his parents think of him are different and he begins to distrust his own thoughts and feelings. His solution is not to communicate his unhappy thoughts and feelings to anyone. This builds up to a person in the late teens with potential high suicide risk.

Acting Out Depression

Suicidal thoughts and attempts are most common in this group. The number of youngsters who fit this category began increasing in the early 1970's. Although there may be many white males in this group, there is a larger proportion of ethnic groups and females than in the other categories. These youngsters are characterized primarily by behaviors that are seen by others as illegal, dangerous, disruptive, harmful, or hostile. The major symptoms represented by people in this category are that of drug and alcohol abuse, running away, petty crimes (e.g., shoplifting and joyriding), assaultive behaviors (frequently with members of one's own family), and occasionally, serious violence. Psychodynamically, these youngsters experience in their early teens surges of depressive feelings that they are unable to understand, explain, or cope with. They often experience and interpret these feelings as painful boredom, and frequently, through role models in their nuclear or extended families, they decide that the most effective way to cope with these feelings is through some form of action. The action, which often includes substance abuse, typically helps them get through the most difficult part. They keep doing it as long as it works. However, these people often get in trouble, particularly with the authorities, who treat them as delinquents rather than depressed youngsters, adding to their sense of despair. These children often come from broken homes, where chaos, inconsistency, and substance abuse is not uncommon. Learning to use alcohol and drugs as a solution to their problems is very frequently something that comes directly from a parent or older sibling.

The Crisis Suicide

Youngsters who evidence suicidal behaviors and symptoms who fit into the crisis category probably represent less than 15 percent of all suicidal youngsters. The major findings among these kinds of persons are that there is an apparently normal pre-morbid personality, no history of severe emotional trauma, and a reasonably stable family pattern.

The typical pattern is that of an adolescent who reaches a point in his life where he becomes aware of, or has inflicted upon him, sudden traumatic changes. The changes may include the loss of a loved one or the loss (or threatened loss) of status in school through academic or atheletic failure. Subsequently, the youngster undergoes sudden and dramatic changes in behavior that may include loss of interest in things that were previously important, sudden hostile and aggressive behaviors in a previously placid youngster, and signs of confusion and disorganization. There is typically an inability to concentrate, and frequently, a series of classical depressive symptoms.

The Psychotic Suicide

This category of youth suicide is somewhat smaller in numbers than the others, and psychologically, are very difficult to work with. The symptom picture often includes delusions, hallucinations, and occasionally, direct messages from voices to kill oneself. Much of the fantasy and some of the behavior of these youngsters would be considered violent and bizarre. The suicidal behavior itself is often bizarre.

These youngsters most often come from single-parent families, i.e., at least families in which only one parent is psychologically present. Sometimes the parents are grossly psychotic, alcoholic, or both; sometimes, the behavior patterns are quite varied and they resemble other categories of suicidal youngsters. But the decision to place the youngster in the particular category of the psychotic suicide is determined by the bizarre symptoms combined with suicidal behavior.

Suicidal Behavior as Communication

This final category focuses on a rather large number who attempt to threaten suicide and for whom communication is a major factor in their suicidal behavior. It is a much less frequent category when examining suicide deaths. In these cases, the person becomes suicidal when more common avenues of expressing frustrated feelings become blocked, interrupted, and stymied. This is not to say that the young suicidal person who is communicating through suicidal behavior is doing so in a calm, rational manner. The experience of a person is usually one of desperation, unhappiness, and great upset. But the lethality of the behavior is almost always low. The ultimate purpose of the behavior seems to clear the way, to open up and break through the barriers, so that the significant others will know how desperate or how unhappy he feels. This represents the classical "cry for help." This suicidal youngster does not necessarily have a history of severe disturbance or prior suicidal episodes, although they may be present.[8]

Warning Signals

Depressed youths will usually display one or more of the following symptoms:

"It is impossible to draw a single, simple portrait of the typical young suicide victim."

1) Change in personality (sadness, withdrawl, irritability, anxiousness);
2) Change in behavior (lack of concentration on school, work, or routine tasks);
3) Change in sleep patterns (oversleeping, insomnia, or early waking);
4) Change in eating habits (loss of appetite and weight or overeating);
5) Loss of interest in friends, sex, hobbies, or activities previously enjoyed;
6) Worry about money or illness, either real or imaginary;
7) Fear of losing control (going crazy, harming self or others);
8) Feelings of helplessness and worthlessness ("Nobody cares," "everyong would be better off without me");
9) Feelings of overwhelming guilt, shame, self-hatred;
10) No hope for the future ("It will never get better; I will always feel this way");
11) Drug or alcohol abuse;
12) Recent loss through death, divorce, separation, broken relationship, or loss of job, money, status, self-confidence, self-esteem;
13) Loss of religious faith;
14) Suicidal impulses, statements, plans, giving away favorite things, previous suicide attempts or gestures; and
15) Agitation, hyperactivity, and restlessness to indicate masked depression.

What causes the depression? Authorities believe that a combination of genetic and environmental factors are probably responsible. It is known, for example, that children of depressed parents and grandparents have a far greater chance of developing the disorder than those without depressed relatives.[9]

Whether this is caused by an inherited chemical imbalance in the brain or by children mimicking the behavior of depressed adults around them, or both, is unclear. However, there seems to be general agreement that a depressed child is often the victim of "many losses." Divorces, deaths in the family, constant moves and separations (especially in the first few years of life), coupled with a loss of self-esteem brought on by abusive parents, are usually part of the pattern.

It is also true, though, that not every child who experiences such losses suffers from serious depression. Some children are more resilient and invulnerable than others for reasons that may never be understood.

Prevention

What can be done to prevent these tragic deaths? Parents who suspect their child is depressed should choose a comfortable and relaxed time to talk to the child about his feelings and problems. Sometimes all it takes to lift a depressed child's spirits is to give that child special amounts of attention, affection, praise, and emotional support. Provide the child with opportunities to regain or boost their pride, ego, and self-esteem.

For law enforcement personnel confronted with a potential suicide, it is important not to act as if nothing is wrong, according to the American Association of Suicidology. Talk to him; listen to him; draw him out; let him know you are concerned. Most people who attempt suicide do not really want to die—at least not at first. It is only when no one responds to their signals that they become convinced that their only option is death. Do not be afraid to ask: "Do you sometimes feel so bad you think of suicide? Just about everyone has considered suicide, however fleetingly, at one time or another. There is no danger of "giving someone the idea." In fact, it can be a great relief if you bring the question of suicide into the open and discuss it freely without shock or disapproval.

Raising the question of suicide shows that you are taking the person seriously and are responding to the potential of his distress. If the answer is, "Yes, I do think of suicide," you must take it seriously. Then continue with other questions, such as: Have you thought how you would do it? Do you have the means? Have you decided when you would do it? What happened then? If the person has a definite plan, if the means are easily available, if the method is a lethal one, and the time is set, then the risk of suicide is very high. Your response will be geared to the urgency of the situation as you see it. It is vital not to underestimate the danger. Ask for details.

Do not leave a suicidal person alone if you think there is immediate danger. Stay with the person until help arrives or the crisis passes. Nearly everyone can be helped to overcome almost any kind of situation which might destroy their self-confidence if they have someone who will listen, take them seriously, and help them feel worthwhile and wanted again.

Common to almost every suicidal crisis is a strong ambivalence: "I want to kill myself, but I don't want to be dead—at least not forever." What most suicidal people want is not death but some way out of a terrible pain of feeling, "Life is not worth living; I am not fit to live; I am all alone with this; I don't belong and nobody cares." After being allowed to unburden, without interruption—without being judged or criticized, or rejected or told what to do—the tension drops, the pain is relieved, and the suicidal feelings pass—maybe not forever, but for now. Suicidal kids just want to know someone cares. The key is to listen. If the person is hallucinating, influenced by drugs or alcohol, if the danger of suicide is imminent and the means are available, obtain professional help. Do not carry on alone. Talk in confidence to a person trained in suicide prevention. If someone is in trouble, there are many resources. These include school counselors, local suicide prevention programs, crisis hotlines, and psychologists and psychiatrists.

Conclusion

Youthful suicide is a serious national problem for society as a whole that calls for total involvement. There must be an increased public and national awareness to this problem and an expansion of community-based strategies for addressing it.

An educational program must be undertaken to alert parents and local institutions with which our youngsters came into everyday contact—schools, churches, athletic organizations, volunteer and youth services groups, recreational clubs, parent/teachers associations and others—to the signs and symptoms of potential suicide victims. Progress will be made when all members of our society are better educated and made aware of the very serious nature of this problem. The youth of America are our most priceless assets.

FBI

Footnotes

[1]Dorcas R. Hardy, *Juvenile Justice Digest*, Assistant Secretary, Human Development Services, U.S. Department of Health and Human Services. June 17, 1985, p. 5.

[2]Arthur S. Freese, *Adolescent Suicide, Mental Health Challenge*, 1st ed. (Canada: The Public Affairs Committee, 1979), pp. 7–8.

[3]Peter Giovacchini, *The Urge to Die—Why Young People Commit Suicide* (McMillan Publishing Co., 1981), pp. 45–80.

[4]Andre Haim, *Adolescent Suicide* (International University Press, 1974), pp. 40–50.

[5]Pamela Cantor, "Teen Suicide," *People Magazine*, February 18, 1985.

[6]Supra note 3, pp. 101–122.

[7]Michael Weiss, "The Riddle of Teenage Suicide," *Ladies Home Journal*, June 1984.

[8]Maurice L. Farber, *Theory of Suicide* (Funk and Wagnalls, 1968), pp. 117–230.

[9]Robert Barry, et al, *Police Work with Juveniles and the Administration of Juvenile Justice* (Thomas Books, 1982), ch. 6.

[10]Dr. Michael Peck, Los Angeles Suicide Prevention Center, Lecture of Delinquency Control Institute, University of Southern California, 1984.

Drug Arrests On The Rise

Over the past 5 years, the number of heroin and cocaine arrests by local law enforcement agencies rose 167 percent, according to recent Uniform Crime Reporting figures. This increase could be attributed to the emphasis placed on drug enforcement policy and the acceleration in criminal activities involving heroin and cocaine. During this same time frame, 1980 to 1984, arrests for marijuana increased only 3 percent in volume, due to a significant decrease in marijuana arrests among those under 21 years of age.

Although heroin and cocaine are gaining prominence in law enforcement arrest statistics, marijuana continues to be the drug most frequently resulting in arrest. Numerically, heroin and cocaine accounted for 1 of every 4 drug violation arrests last year, a shift from the 1 of every 8 ratio in 1980.

Data on heroin and cocaine arrestees showed every age category increasing from 1980 to 1984. The number of arrestees under 21 more than doubled and those aged 21 and older nearly tripled. However, for marijuana, there were 27 percent fewer arrestees in the under 21 age group, while the 21-and-over category registered a 37-percent increase.