Adolescent suicides essay

Suicide is an act where one intentionally ends his/her own life. (Berman, 1992).

Suicide has existed for a long time and has increased substantially in the past 2-3 decades among adolescents (Hawton, 1986). In order for a death to be considered suicide it must be ones own doing, where the person intentionally used a physical action to kill himself; this is different from an accidental self-inflicted death.

If a suicide does not result in death, it is labeled as an attempted suicide. Statistics show that suicide rates in Ontario between 1971 and 1977 have increased by 42%, for adolescents and young adults between the ages of 10 to 24 years old. Suicide is the fifth leading cause of death for adolescents, where age, sex, and race are important risk factors (Berman, 1992). Hawton (1986) agues that there has been a great amount of adolescent suicides that have gone unreported due to;

1.

The relative rarity of the event in this age group may make thoseresponsible for determining the cause of death unlikely to consider suicideas an explanation; 2. Even if suicide is considered a possibility, the widely held belief that small children rarely commit suicide may mean that there is a greater tendency for death in this age group to be mistakenly reported as accidental. Subsequent suicide statistics will therefore confirm the belief that suicide is uncommon in children; 3. Those responsible for reporting suicide may be, consciously or unconsciously, concerned to protect other individuals from distress that a verdict of suicide may cause.

Parents are particular liable to feel not only grieved but guilty about the suicide of a young son or daughter and the death may be reported as accidental or of undetermined cause in order to protect their feelings; 4. The predominant religious beliefs of a country or society are also likely to be important. For example, the Roman Catholic Church regards suicide as a mortal sin, and so officials in predominantly Catholic countries such as Italy and Ireland may be less likely to believe that a person has committed suicide than in predominantly Protestant countries. (p. 17-18)

My paper will discuss the reasons for adolescent suicides; the methods of suicide; euthanasia; prevention of suicide and how social workers can help with intervention.

Reasons for suicides in adolescents.

There are methodological problems in studying the reasons or causes of suicide in adolescents because many aspects of a victims life may have gone unreported. In addition, there may be difficulty in collaborating information from siblings or family members of the victim, as this is a very emotional topic to discuss, and the guilt may cause them to forget certain things (Hawton, 1986). Therefore, in order to study the reasons for suicide, researchers must compare characteristics and family history of people who commit suicide to those who do not. I believe that there is not one underlying cause for suicide but many, which center on inner needs that are not being met. People who commit suicide are looking for an escape to their problems. Adult evaluators view adolescent suicide attempts as

manipulative and hostile acts designed to punish and/or control significant others in their environment (Curran, 1987, p.

44).

I do not completely agree with this view, because it is vague and does not explain ones in-depth psychological reasoning to kill oneself. One study showed that the distinguishing characteristics among adolescent suicide attempts, included divorce in their family, moves, and school changes. They all viewed these events as unhappy and negative (Curran, 1987). Additional factors that may result in suicide include broken homes where there are stepparents, parental psychiatric disorders, and young marriages.

In a study on adolescent suicides, 40% of all the attempters had a stepparent (Curran, 1987).

The stepparent was regarded as unwanted in their family. Stepparents can be perceived to be the cause of a divorce, and there can be a lot of jealousy over the attention that he/she is receiving. In a 1974 study, 55% of 30 cases were found to have a family history that involved psychiatric consultation (Hawton, 1986).

This is significant, because a psychiatric disorder can contribute to suicide in many ways. Hawton (1886) outlines them as the following;

1. Genetic predisposition to depression or other serious mental disorders are common among suicides; 2. Living with depressed relatives may mean a young person lacks affection and feels rejected; 3.

Depressive disorder in a parent or older sibling might serve as a model for the individual encouraging adoption of a morbid or hopeless attitude; 4. Child/Adolescent may find it intolerable living with a parent or sibling with a major psychiatric disorder. (p. 38)Even though small portions of adolescents are married, the stresses of a young marriage can contribute to suicide. Teenage marriages commonly represent a hastily escape from unsupportive family backgrounds and that such marriages often rapidly encounter major problems (Hawton, 1986, p.

28). There are many possible reasons for adolescent suicides, however they all share the common notion that these children are searching for an answer and solution to questions and problems that can not seem to be answered.

Methods of suicide.

Suicide rates among adolescents tend to be higher in the daytime during the months of April and May and lowest in December and January (Crow, 1987). It is believed that the adolescents are skeptical up to the point of committing the act, and want someone to find them before they die. In North America, the most popular means of suicide is firearms.

Approximately 60% of all suicides result from gunshots, at an equal rate for males and females. In Canada, guns are commonly used in rural areas, while drugs and jumping from heights are mostly found in urban areas (Crow, 1987). Hanging and strangulation is the second most common method of suicide, used in 1 in 6 suicides. Poisoning through the ingestion of chemicals is used in 8% of all suicides, at a rate of 5 times higher for females than males.

Jumping from a high place is used in 3% of all suicides, and cutting or puncturing oneself is used in less than 1% of all suicides (Crow, 1987).

The methods used for suicide are influenced by a vast majority of factors and have a major impact on the likelihood of death (Berman, 1992). I believe a person will choose an immediate method over one that will take time to work, depending on how serious they are about committing suicide. If they really feel that they cant live a minute longer, they will use a gun or hanging.

On the other hand if they feel a bit skeptical or if it is on the spur of the moment, they will use drugs or cutting. The least to most lethal methods of suicide are gunshots, carbon monoxide, hanging, drowning, plastic bag over head, fire, poison, drugs, gas, and cutting. In a study on suicidal students factors such as painlessness, availability and non-disfigurement appealed to choosing drug overdose, whereas the students selecting guns cited the quickness of this method. (Berman, 1992, p.

383). No matter what method a person uses to commit suicide, it usually is an escalated decision. Most people who commit suicide move through a four-step process of progression. Curran (1987) views these steps as;

1. A long standing history of problems from childhood to the onset of adolescence; 2. A period of escalation of problems since the onset of adolescence and in excess of those normally associated with adolescence; 3.

Progressive failure of available adaptive techniques for coping with old and increasingly new problems leading to a progressive social isolation from

meaningful social relationships; 4. Chain reaction dissolution of remaining social relationships immediately prior to the suicide attempt. (p. 52).

Euthanasia as a type of suicide.

Active euthanasia is usually taken to mean the administration of a poison or pain-killing medication in a dosage sufficient to kill the patient (Gentles, 1995, p. 2). This is separate from murder, because the patient gives or implies consent. Active euthanasia is however illegal throughout the world, excluding the Netherlands.

Assisted suicide is distinguished from active euthanasia in that the person must take deliberate steps to bring about his or her own death. Medical or other personnel may provide assistance, but the act of suicide is committed by the patient (Gentles, 1995, p. 2). Euthanasia and assisted suicide are very controversial topics, that have raised legal, ethical and social questions that are complex and disturbing (Gentles, 1995).

I personally agree with voluntary euthanasia or mercy killing.

If a patient is dying and suffering a great amount of pain, and they ask to have the plug pulled, I believe it is their right. I am however skeptical about involuntary euthanasia, where a patients life is ended without out their consent or against their wishes. No matter how this is argued it is seen as murder. Voluntary euthanasia, as a means of suicide is the only type I agree with, and the only type that should be justified.

As adolescent are using suicide as means to deal with stress and other problems that they can get help with, euthanasia is separate case altogether, which involves the legal system.

Prevention of suicide.

When attempting to prevent suicidal behavior one must look at primary and secondary prevention. The principal aim of primary prevention is prevention of any suicidal acts in the first place, whereas that of secondary prevention is prevention of further suicidal behavior once an individual has made an attempt. (Hawton, 1986, p.

129). For primary prevention of suicide it is important that we improve our social and psychological welfare programs. Hawton (1986) states;

Some broad measures that have been suggested include social support to poorly functioning families; improvement in the diagnosis and treatment of depression and other psychiatric disorders in childhood; an increase in educational programs in child and adolescent psychiatry for family doctors and hospital and community physicians; and courses aimed at helping parents, teachers, and social workers become more aware of the problems of young people. (p.

129).

In addition, I believe a young person should have someone they can talk to and trust in times of stress. This person would be there to listen, give advice, but not judge the adolescent. This would be useful in preventing suicide, because the adolescent would not feel alone in a world, where no

one understands them or their problems. Secondary prevention of suicide should be aimed at improving the patients social and psychological difficulties (Hawton, 1986). I believe that, once an adolescent has attempted to commit suicide, he/she will not be afraid to do it again.

This means, that the adolescent should be watched carefully, and admitted into a therapy program. Prevention is perhaps best considered as part of a wider approach to helping equip young people with coping skills (Hawton, 1986, p. 137). Once adolescents have the skills necessary to deal with stress, he/she will be able to find better alternatives than suicide.

A social workers intervention in suicide.

In order to look at how a social worker can intervene in suicide, we must first look at the conflict state.

This is the basic social interaction situation leading to crisis and to the need for crisis intervention (Crow, 1987). The crisis is understood in terms of how the young person is or is not getting along within his/her total situation. Conversely, the crisis lies in how other people within the total situation are or are not getting along with the child (Crow, 1987, p. 19).

A social worker can come in at this point and work with the child to develop their rational reasoning planning dimensions in ways that help the child gradually to understand and cope with his crisis (Crow, 1987). The social worker must pay close attention to the individuals feelings, emotions, thoughts, ideas, abilities, limitations, and personality. It is crucial that that the social worker works with the whole, multi-dimensional person. This

would include everything in his external environment that affects him or is affected by him (Crown, 1987).

The individuals total situation includes then and when. Then is the individual past, and it shapes and affects the way things are now in his present. It is important to see that when is not the future; rather, it is the ways the individual feels or thinks the future will be when certain things happen or do not happen, when he does or does not accomplish some goal, if circumstances change or do not change, and so on (Crow, 1987, p. 21).

Through interaction with the individual and his total situation, a social worker can find out if there is really a crisis, to help the individual resolve. If there is no crisis the intervention will help the alarmed family, friend, teacher, or others calm down and better understand the situation (Crow, 1987).

If a problem in the conflict state goes unresolved, it will then shift to a more serious crisis state. In this state there is a now potential and a low self-resolution factor. The now potential refers to how quickly the adolescents situation can deteriorate into one where they cannot find answers to their problems. A social worker at this point would intervene and try to find out what happened, develop a picture of the individuals total situation, and by interacting the two, develop a judgment about the now potential of a crisis (Crow, 1987).

If the self-resolution factor is low, which means the individual cannot handle the situation himself, the social worker must find someone in the total situation that has the knowledge, skill, and capacity to deal adequately with it. This person can work along with the social worker to modify the

adolescents situation, so that it is in the best interest of he/she. For the social worker to ensure that he/she has a crisis focus, he/she should ask themselves specifically; what is likely to get worse; how bad might it get; if things get worse, what is the potential effect and on whom; and why do they think the individual or someone else in the crisis might not be able to deal with it (Crow, 1987, p. 31.

It is crucial to crisis intervention to have a crisis focus. If not, then the social worker, may be helping the client with a problem that they do not have, while the real problem is going unsolved.

It is also important for the social worker to know the three crises that involve threats of suicide. These include severe family difficulty or disruption, having done something or having experienced a situation that causes extreme feelings of guilt or worthlessness, or some external event that threatens an individuals social or personal sense of well being (Crown 1987). A social worker should then know the possible causes of these crises, to better help their client in crisis intervention. Another aspect of crisis intervention that a social worker should be aware of is crisis communication.

I believe this is one of the most important aspects of the intervention process. If a social worker does not deal with communication effectively the patient will not get the help that he/she needs in clarifying their thoughts and feelings.

If this occurs, then the patients additional distress can bring about suicide. Crow (1987) says that crisis communication must lead to modification and clarification of their feelings, emotions, and ideas, thereby enabling them to

better deal with their present situation (p. 44). It is also important for the social worker to make the patient feel comfortable talking to him/her and let the patient know that they care.

This means that the social worker should act as a rational, objective, feeling, caring sounding board for the patients feelings and ideas and as an emotional filter through which his feelings and ideas can pass (Crow, 1987). Encouraging assessment of the situation should be part of crisis communication. This is where the social worker gets the individual to think about himself, his situation, and the interaction between him and his situation.

The social worker is getting the individual to find the reasons for the crisis, which in turn can bring about solutions.

I believe if the individual is actively involved in the assessment stage, he/she will not only stop blaming himself, but also feel as if they have some direction and clarification as to where things went wrong. The individual is then able to think more clearly, analyze more thoroughly, and plan more carefully. In turn the individual is using the social workers skills to enhance or supplement his own skills (Crow, 1987). The final stage of the intervention, would be developing possible solutions and evaluating them. At this point the individual and the social worker have some understanding as to what has happened or is happening.

By this point the social worker should have helped their client come up with possible options for his/her situation.

Breaking down the clients big problem, into smaller manageable problems would be a good way to deal it. The social worker should ensure that they have met all the clients needs, and that there are no outstanding issues or problems. It is the social workers responsibility to now check in with their client to make sure that he/she is stable, and that the problems are being dealt with effectively. I believe that this is very important to the entire intervention process, because if the client feels that their time with the social worker was a waste, he/she will be reluctant to see another social worker again.

If the solutions to the problems do not work, the client might give up entirely and result to other self-destructive means.

The crisis intervention process mentioned above can be as brief as one to ten sessions or as intensive as a few weeks, depending on the state and seriousness of the patient and his/her problems. However, if the case cannot be dealt with by a social worker, then they may use other therapeutic strategies such as; referrals to other specialist agencies, and very occasionally, medical assessment for a prescription of psychotropic drugs (Hawton, 1986). Whether or not the social worker decides to deal with the patient it is essential that he/she find the appropriate help for the individual. I believe time is very crucial for a person considering suicide, and that they should get immediate attention.

CONCLUSION

Suicide is an act where one intentionally ends his/her own life.

Suicide has increased tremendously over the past couple decades among adolescents. This could be the result of the many stresses that young people have to deal with in their life. Weather if it is the result of coming from a broken home with alcoholic parents, or the stresses of just being a young adult, social workers today must effectively intervene to help these adolescents effectively deal with their problems. There are many methods and reasons for suicides, but the underlying factor is that children who have suicidal thoughts, behaviours and acts are trying to tell someone something, and they are looking for answers and solutions to questions and problems (Crow, 1987).