Adolescent suicide.

Authors: Martin, Graham

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Abstract: Part III. Discusses the clustering phenomenon in which publicity of a student suicide story appears to lead to imitation in a series of student suicides in Australia. Case histories and connections; Tendency of a student to copy the method of a reported suicide case. INSET: Suicide prevention support and resources..

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Adolescent SUICIDE

Listen American Accent

3 Imitation and the clustering phenomenon

The final part of this series on adolescent suicide further where local publicity appeared to lead to imitation in a series of student suicides in Adelaide.

The author's investigation into a series of suicides and attempted suicides in teenagers shows that clear, if at times tenuous, links existed to suggest that a process was occurring which entailed imitation.
The figure opposite demonstrates an adolescent suicide cluster and shows the minimum links which have come to light with regard to teenage suicide and attempted suicide (age range 13 to 18) over a two-year period from 1988 to 1990. Six different schools are represented; individual adolescents are represented by fictitious initials and the underlined initials represent attempted suicides. Completed suicides are indicated where the year of the suicide appears under the initials.

Case histories and connections

CD was in Year 11 at school 2. An intelligent youth, he had been struggling with the demands of academic work, but was friendly, part of an outgoing fun loving group, and had a number of close friends from several schools. Like many risk-taking youngsters he drank alcohol as often as the group could get it and smoked marijuana regularly. Over several weeks after he discovered that his father had a terminal illness which was likely AIDS related, CD became withdrawn, unapproachable and talked on several occasions about life being not worth living. His friends would agree and then they would go off to yet another party and get stoned. One morning CD phoned a friend; he was upset and attempted to say his goodbyes, His speech seemed slurred and his friend was concerned. Eventually CD admitted to taking sufficient of his mother's sleeping tablets to kill himself. The friend went round to the house and tried to break in. When they found CD he was dead -- probably from inhaled vomit.

The impact on the group of friends and classmates was enormous. In the immediate few days after his death, a team of counsellors attended the school and did grief work with close friends. Over subsequent weeks staff at the school, other students and parents all needed support from combined school counsellors, senior staff, priests, and therapists from Child and Adolescent Mental Health Services.

A memorial service one week after CD's death was attended by the whole senior school. That night there was a wake at a friend's house and in the course of the evening, NT, a friend from another school who was also one of the pall bearers at CD's funeral, "missed his footing" and fell down a spiral staircase sustaining terminal head injuries. Little detail is known of this incident or of the boy's personal life.

The day after NT's "fall", EF, a Year 9 boy from CD's school, was sitting in his bedroom with a loaded gun in his mouth. The details are obscure, but as his father tried to get into the room, the boy pulled the trigger. Again school 2 mourned his "accident" and support services became involved.

As a postscript to CD, a girl (FB) who was part of CD's circle of friends at school 2 and who sat behind him in class for all of that year, had a younger brother, AB, (previously at school 1) who

had committed suicide in 1987. No details are available of this incident.

Over the next six months at school 3 MN was referred for"difficult behaviour" at school, OP was referred for "depression", and QR was referred with her family for "difficulty in communicating". All three girls were in the same Year 11 class at school 3 and although a year younger than CD, all had been part of the social group around him.

MN was in trouble with teachers at school for angry outbursts, refusing to do set work and taking alcohol to school. Her behaviour at home had become erratic over the previous months, there had been fights with her parents and she had increasingly stayed away from home. Eventually she moved into a granny fiat behind the house of a maternal aunt where her drinking behaviour, frequent parties, loud music and abusive behaviour could continue without too much interruption. In therapy she was hostile and abusive and she continued to deny problems until she was able to discuss what had happened to CD. MN continues to be "difficult", but has not repeated her self-destructive behaviours and did complete Year 12 at school.

OP fell out with her boyfriend, ST, about one month after CD's death. She attempted suicide, was seen by a psychiatric service, but denied problems and her family did not attend crisis therapy sessions. She continued to be depressed, avoided the group of friends, spent days at home with a series of minor ailments and her school work suffered. Eventually the school persuaded the family to seek assessment and help. OP needed considerable grief counselling regarding CD's death but also for a series of other events in her life.

QR came to therapy incidentally. Her older brother, BR, was referred because of increasingly erratic and difficult behaviour. His alcohol consumption had increased, he spent almost every night of the week at other friends' houses, he became unhelpful at home and frequently abusive. His Year 12 work (his second attempt to matriculate) at school 3 declined and the school had demanded that he "pull his socks up". His mother had been a single parent for many years but had managed university (with several part-time jobs) and developed a professional career. However, there had been a series of disastrous personal relationships and home life had been very "unsettled". QR took little part in the initial family sessions but was friendly and polite, if quiet. There was no hint of a major problem until her brother mentioned the impact the death of CD had had on him. QR became distraught and several further family sessions were necessary to explore feelings and experiences before both QR and her brother were ready to make clear decisions about the future.

UV had been in the same year at school 3 as MN, OP, QR and ST. Toward the middle of 1988, having previously been an excellent student, she had increasing trouble with her academic work. In part this was because the crowd she mixed with believed she was a goody-goody and "sucked up to" the teachers. UV preferred to keep her friends, but even in failure she was the butt of verbal abuse and in desperation was moved to school 4 into a class with XY, ZA, BC, DE and FG. She continued some of her friendships at school 3 and also had a

number of friends at school 2, among them the group around CD. Throughout this time she was in individual therapy and the family was seen far regular family therapy. Despite this UV began to drink heavily after CD's death, attempting suicide on a number of occasions -- by medication and by cutting across a live electric cable with scissors. The parents were particularly anxious about the suicide attempts because the father had attempted suicide himself as a young student and was "rescued" by the mother. This had remained a family secret. UV was admitted for intensive assessment of her depression to a general hospital paediatric/child psychiatry unit, and when they could not contain her acting out behaviours she was admitted to a private psychiatric hospital. During her stay there she made further suicide attempts (one involving 132 Panadol). UV kept up her contact with her class during her stay and made academic progress. Only three friends visited her in hospital- XY, ZA and BC. The message they carried from the class was ambivalent: "Things are so much better without you. No! Only kidding. Get well soon." It was some months before angry acting out behaviours and repeated verbal abuse to her family settled enough for her to go home in March 1989.

In April 1989 XY (the case history referred to in Part 2, p.24-25) committed suicide by jumping from an eight-storey car park roof. She had talked for some months with her friends and classmates about the possibility. Scribbled notes from that time stored in a shoe box show that the others were happy to describe their own depressed thoughts and suicide attempts. All of her friends advised XY that she would get over her thoughts. She had very mixed feelings about taking a boy (ST) to the school formal two weeks later, and was anxious that she would be publicly disgraced or shamed in some way. As described in Part 2, XY had made very careful plans to suicide, writing to each of her friends and dividing up her belongings into 13 brown paper bags which she labelled with friends' names and left with the letters in her school locker. The night before she died, she made an audiotape for her best friend -- an attempt to allay the grief and guilt she was sure the friend would feel.

The day after XY's suicide, ZA (case two, p.26) went home from school and attempted suicide by taking medication and then blocking off all the doors and windows in the kitchen and turning on the gas. She was found unconscious by her mother who returned home from work earlier than expected. ZA, at 17, had a long history of acting out behaviours, promiscuity and drug and alcohol abuse. She came from a single parent, professional family where the mother herself had a history of recurrent depressions and attempts at suicide. In therapy ZA confessed that XY had had so much better a life than she, that she envied her successful suicide and felt she had "much more right to die".

In the post-suicide intervention at the school two weeks after XY's suicide, it was discovered that DE (case three, p.26) had attempted suicide about two weeks before XY's death. She had taken a sublethal dose of her mother's medication in the belief that she would die. When she woke the next morning she was relieved to be alive and swore to herself that she would not repeat the experience. She did not seek medical assistance. After XY's death DE became much more openly depressed and for the first time began to work in the counselling

relationship she had been in for several months as the result of depression.

Detailed examination of the scribbled notes from friends that passed between them during lessons revealed that BC (case four, p.26) had a written pact with XY: "Is our appointment still on for . . . Parking Station, otherwise I will have to do it on my own . . .?" BC was the second child in an intact professional family. It was difficult to discern family discord or other major reasons for her depressed affect. She was consistently haughty, sarcastic and defensive in therapy and refused to return after the second session, denying personal problems. The family said that they would make further arrangements should the need arise.

In 1990, HI, a 17-year-old Year 12 boy at school 5, committed suicide by hanging. He was the youngest child of immigrant parents both of whom had serious illness. A high achiever, particularly at music, he felt under considerable strain from the academic demand of the matriculation year. The special conflict, however, seemed to be around not being able to separate from the family and involve himself with friends in their round of parties because he felt responsible for his parents and was already beginning to work through the grief of their loss. He made very careful plans to ensure his suicide was not interrupted and had also engineered time with a special teacher, thanking him for his support, shortly before the act. He left an explanatory note for the same teacher.

Because of previous successful postvention exercises in schools following suicide, a multidisciplinary team was called in to work with staff, students and parents the day after HI's suicide. From an open invitation, 15 young people from the same year opted to attend a clinical group with the aim of dealing with immediate grief issues. A second explicit aim of the professionals involved was to identify any young people who appeared particularly vulnerable so that they could be offered special support or therapy. Two teenagers seemed more upset than others. One had a father who had recently died and the episode had reopened his grief. The second boy, LM, spontaneously offered that this was not the first suicide of a close friend he had experienced. He recalled that he had taken out a girl, XY, on one occasion and had made plans to go out again if her parents allowed. Both boys entered supportive therapy.

A few weeks later the author was called to school 6. NO had attempted suicide with eighteen Diazepam tablets -- a non-lethal dose which he had believed would kill him. NO was from the country and a boarder at school where he had received considerable teasing for his small stature. He was desperate to return to the local country high school. He had planned the suicide attempt for a long time and had removed the tablets from his mother's supply slowly over some months, hoarding them for the right occasion. As part of the assessment he volunteered that he had considered several methods of suicide, and had opted for the tablets which seemed to be the least painful. He had considered jumping from the parking station and his response to a question about how he had thought of that idea was that he had heard of a girl the previous year who had successfully suicided: "My sister (CO) told me . . . she was at the same school . . . I went and had a look and it was easy, but I thought it would hurt too

much."

Discussion

This paper describes the author's personal knowledge of a trail of suicide and suicide attempts over two and a half years. Many of the survivors and friends have been in therapy with the author or close professional colleagues. The links described are often tenuous, and much of the detail is missing. It is often difficult to seek information of interest to the therapist when such information has not arisen spontaneously in assessment or therapy, or does not appear to be of interest or appropriate to discuss at the time. While the curiosity is burning, the need to remain ethical is stronger. The information given here is therefore that offered freely to the author. Presumably there is information known to others about the episodes described, or about incidents not known to the author which would clarify the processes described. Such information may or may not come to light. Nevertheless the information described provides compelling support for the idea that teenagers do imitate their peers.

The literature in the main has focused on a general effect- that is, a real episode being described in the print media, or a real or fictional episode referred to on television. Conflicting research has suggested that reports may have either a local or national effect, may affect those without prior suicidal thoughts, or may only affect especially vulnerable people. What appears to be generally accepted is that imitation occurs and that teenagers may be particularly prone to this.

What this paper sets out to report is that suicide is a personal affair. In most of the cases described the teenagers had a clear history of previous difficulty good evidence, if sometimes retrospective, to suggest that they were depressed and had suicidal thoughts. In most cases there is clear evidence of a troubled home life with a particular crisis (personal, home or school) triggering the act. The suicide or suicide attempt does not come out of the blue. A young person is not likely just to decide to suicide because a peer has, or because they saw an episode of fictional suicide on television. It appears that there must be personal and family difficulties which provide a context.

Early reports of the "copycat effect" suggested that a teenager may copy the method of a reported case. This may or may not be true. It appears that teenagers like other people can decide for themselves what is available to them or most convenient or least painful.

The influential aspect which appears from this work and the therapy with young people that underpins it is that increasingly teenagers believe that suicide is simply a reasonable option to be chosen or not when circumstance demands. It is likely that this is to do with such general societal changes as the abolition of religious sanction against suicide. It may also be to do with the constant diet of death and destruction that teenagers have access to on film and television, and which may devalue human life. If something is experienced frequently enough, then by definition it becomes normal, the average, of lesser import. One common challenge from teenagers in therapy is to do with the anxieties we adults are supposed to feel about suicide.

The "hang-up", it is suggested, is ours and not theirs.

The link between each of the cases may well be to do only with this "normality": "If CD or XY can suicide when their life circumstance was better than mine, one option open to me is to take my own life. I may and can do that if things get worse."

It is clear that the process described here is likely to continue. For every completed suicide there are a number of vulnerable teenagers who will be affected by the death. The closer the suicide was in terms of friendship or association, the stronger the effect.

Vulnerable teenagers can be identified using a combination of clinical assessment, joint discussion with education and welfare professionals and the use of suitable questionnaires. A completed suicide is difficult to predict. However, in a school or closed community suicide yields an opportunity to provide appropriate counselling services to students, staff and parents. In particular it provides an opportunity to identify the vulnerable teenager and provide the special care necessary. Such postvention may help to curb at least the spread of a pseudo-normality -- an apparent acceptance by adolescents of suicide as OK.

DIAGRAM: Adolescent Suicide Cluster

Underlined initials indicate attempted suicides.
Initials and year indicate completed suicides.
ILLUSTRATION: SCHOOL 1

ILLUSTRATION: SCHOOL 2

ILLUSTRATION: SCHOOL 3

ILLUSTRATION: SCHOOL 4

ILLUSTRATION: SCHOOL 5

ILLUSTRATION: SCHOOL 6

Reference

Goldney, R.D. 1989, 'Suicide: The Role of the Media', ANZ Journal of Psychology, 23, pp.30-34.

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By Graham Martin

Suicide prevention support and resources

Adolescent poetry -- The NSW Association for Mental Health has recently launched Love
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which is eternal: Poetry, prose, letters, an anthology of poems and other writing by a young man who was diagnosed as suffering schizoaffective disorder, which was likely to develop into either schizophrenia or manic depressive illness. After leaving home and living independently, he died by suicide at age 22. The NSW AMH recommends the book for young people, workers in the youth sector, mental health workers, and parents and sees it as a useful suicide prevention resource, by assisting adults and adolescents to recognise the signals of distress and educate people as to the early signs and experience of a serious mental illness. The anthology is available from NSWAMH, 62 Victoria Road, Gladesville NSW 2111. Cost, including postage, for NSW $15; other states $18.

The Australasian Association of Suicide Prevention (AASP) was founded in May 1991 by a coalition of individuals and community organisations concerned to bring the facts about suicide to public notice. The Association hopes to achieve a reduction in suicide rates in Australia through encouraging the development of health and education programs and networks with like-minded organisations. It also wants to develop national preventive strategies, encourage professional cooperation and training in the area and provide advocacy and information services. The Association will also be active in forming self-help groups for attempters and survivors. Membership information and forms are available from AASP, PO Box 15, Narellan NSW 2567.

Hearing the Cry -- Suicide Prevention is a book by Margaret Appelby and Margaret Condonis which suggests what signs to look for, what to do and where to go in the interests of preventing suicide. The authors believe ignorance is the greatest enemy and that there are many mistaken beliefs about suicide which, although they do not directly cause the deaths, prevent people from intervening effectively. The book is available from ROSE Education, Training and Consultancy, 20 Northern Road, Narellan NSW 2567. Cost $9.50 including postage.
