Suicide is the fourth leading cause of death during the teenage years, preceded in frequency only by trauma, malignancy, and homicide. Recent statistics indicate that the number of suicides in adolescents has risen dramatically in the past decade, resulting in approximately 5,000 deaths per year. For youths 15 to 19 years old, the figures have actually doubled from 1968 to 1976; 11 boys per 100,000 in the population are now dying by suicide each year. Even among adolescents 10 to 14 years old, the trend is increasing and went from 116 to 158 deaths per year between 1968 and 1976. As distressing as these data appear, it is more alarming to realize that suicides are notoriously under-reported.

Suicide affects youngsters from all races and socioeconomic groups. For every suicide completed, between 50 and 200 are attempted. Boys succeed in their suicide attempts more frequently than girls, mainly because they use more lethal methods, such as firearms or hanging. Girls generally attempt suicide by ingesting pills and are more frequently resuscitated. The pediatrician can provide a significant resource in preventing adolescent suicide by identifying youngsters at high risk and recognizing behavioral clues in youngsters contemplating suicide.

**Depressed Adolescents**

It is sometimes difficult to recognize depression in teenagers because it is common for normal adolescents to have mood swings which at times have a depressive element. Furthermore, depressed adolescents frequently do not have classic symptoms but rather depressive equivalents such as psychosomatic complaints, daredevil behavior, delinquent acts, or truancy. When pediatricians note such behavior in adolescents, they should inquire about feelings of sadness, depression, and thoughts of harming themselves.

**Unwanted Adolescents**

Some adolescents perceive themselves as unwanted or unnecessary to the family; in fact, they may believe that the family would be better off without them. Included in this group are teenagers whose divorced parents continually fight over them, adolescents in financially marginal families who blame the teenager for their monetary problems, and youngsters who feel they have “failed” the family by some digression such as pregnancy, school failure, or trouble with the law.

**Adolescents with Poor Impulse Control**

Teenagers with poor impulse control may precipitously make a fatal suicide attempt without intending a fatal outcome. These youngsters are not as capable of controlling impulsive actions as other youngsters. Included in this group are adolescents with minimal brain dysfunction and youths with episodic violent behavior syndromes.

**Psychotic Adolescents**

Command hallucinations will provoke psychotic adolescents to attempt to take their own lives. This may occur during lucid periods when the teenager
realizes how disturbed he or she is and then becomes terrified.

**Family History of Suicide**

If there is a history of suicide in a youngster's family, he is more likely to attempt suicide during periods of stress, thus modeling his behavior after those around him.

**Serious Trauma**

Any teenager who has a serious accident or burn should be evaluated retrospectively for psychosocial problems because some accidents may be suicide attempts gone awry.

**MANAGEMENT OF THE SUICIDAL ADOLESCENT**

In caring for adolescents who admit to considering suicide or those who were unsuccessful in their attempt, the pediatrician's first priority is obviously resuscitative medical care. However, he is also obligated to complete a thorough psychosocial evaluation and assure that adequate follow-up care is planned. The critical evaluation issues are below.

**Specific Reason for Suicide Attempt**

The pediatrician should attempt to determine the reason for the suicidal action. For most adolescents, suicide represents an attempt to resolve a difficult conflict, escape an intolerable living arrangement, or punish important individuals in their lives. The pediatrician should thoroughly explore, in a nonjudgmental manner, which type of situation applies to each young patient.

**Lethality of Suicide Attempt**

It is important to investigate the seriousness of the suicidal behavior. If the youngster's plan or act involves an elaborate scheme to avoid discovery and one that uses an extremely lethal method, such as shooting or hanging, he is serious about ending his life. Some suicidal actions are simply gestures and not a genuine attempt to kill oneself, but rather a cry for help. McAnarney has described some of the factors that distinguish a suicide attempt from a suicide gesture. However, suicide gestures should not be dismissed as unimportant, no matter how minor the act. The youngster must be told that his plea for assistance has been heard. In fact, by not responding to a suicide gesture, the pediatrician may provoke a youngster to more serious or fatal actions.

**Function in Family, School, and Peer Group**

Teenagers function within a family unit, a school, and a peer group. The pediatrician should investigate how well the adolescent is doing in each of these areas. This information is critical to developing an effective treatment plan. The work of Hammar and Holtermann and Felice and Friedman may assist the pediatrician in sharpening his interviewing skills in talking with teenagers.

**Support Systems**

An assessment of a youngster's support systems includes evaluation of his personal, social, scholastic, and family strengths. A bright, personable, attractive adolescent from a warm, concerned family will probably have a better prognosis than a socially isolated teenager who has dropped out of school, has few friends, and has nonresponsive parents.

On occasion, this evaluation may be completed in an ambulatory setting, particularly when the adolescent has made a suicide gesture of low lethality and has responsive, caring parents. However, it is usually difficult to assess adequately an adolescent on an emergency basis in the midst of family distress and in an emotionally charged atmosphere on an ambulatory basis. In such instances, an adolescent should be temporarily separated from home and family to enable an adequate evaluation. The pediatrician may wish to make the full evaluation and follow some patients himself. Indeed, the trusting relationship developed over the years between the pediatrician and the adolescent is a good basis for a therapeutic alliance. However, most pediatricians who choose to do this should consult with psychiatric colleagues to confirm a "low-risk" assessment. When it is necessary to hospitalize a suicidal teenager, psychiatric services should always be formally requested.

Adolescents who are psychotic or actively suicidal and require constant guarding should be admitted to a psychiatric facility. It is unrealistic and dangerous to expect psychiatric personnel to handle a severely suicidal teenager in the usual pediatric hospital setting. Thus, pediatricians and psychiatrists must establish a close working relationship to respond quickly to the immediate needs of suicidal teenagers.

The results of the initial evaluation will usually indicate the type of long-term follow-up needed. Obviously, a psychotic adolescent should be referred to a psychiatric professional or facility rather than be followed by a pediatrician. If the teenager's suicide attempt is the result of family problems, referral for family therapy may be indicated. When an adolescent’s suicidal gesture is thought to be a “cry for help,” the patient may be treated by a
pediatrician with whom he has already established a trusting relationship.

Involvement with suicidal teenagers by individual pediatricians will depend on knowledge and comfort coupled with appropriate community resources. Some pediatricians can best help by being attuned to presuicidal youth and working to prevent adolescent suicide. Others may wish to evaluate as well as treat some of these youngsters. Still others may choose to refer all suicidal adolescents to a psychiatrist. Whatever role the pediatrician chooses, the most important issue is that each suicidal teenager knows his or her plea for assistance is heard.

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REFERENCES

ON THE UPBRINGING OF CHILDREN BY JOHN PECHEY, WRITING IN 1697

John Pechey (1655–1716), the last English writer on diseases of children in the seventeenth century, had this to say about the upbringing of children.¹

Children if they are virtuous are great Blessings and a publick good. It is therefore the duty of Parents to inure them betimes to a Regular course of Life; nor ought Persons of the best Quality to think the guidance of their Children beneath them. For Cornelia the Mother of the Gracchi, and Aurelia the Mother of Augustus Caesar, were Governesses to Children, and Cato, tho’ he kept a Tutor in his House, did himself frequently instruct his Son. So did Augustus his grand-children, and the great Theodosius wou’d often sit by the Tutor while he was instructing his Son. And certainly it is best and safest for Parents to have their Children under their own Eye and inspection. But above all, the Fathers Example is of greatest force to instruct the Son, and his Actions Authorise the same in the Child, nor can the Father chastize him for what himself is guilty.

Noted by T.E.C., Jr., MD

REFERENCE
Teenage Suicide

Pediatrics 1980;66;144

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Teenage Suicide

*Pediatrics* 1980;66;144

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