Attitudes and Beliefs of Adolescents and Parents Regarding Adolescent Suicide

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WHAT'S KNOWN ON THIS SUBJECT: Suicide is the third leading cause of death for adolescents in the United States. Suicide prevention efforts often involve environmental modification, such as limiting access to lethal methods, and education, such as recognizing individual risk factors.

WHAT THIS STUDY ADDS: This study examines the perceptions of adolescents and their parents regarding the risk, predictability, and preventability of teen suicide and explores what participants think about how to prevent suicide.

abstract

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OBJECTIVE: The goal was to understand the attitudes, beliefs, and perceptions of adolescents and parents of adolescents, from a variety of backgrounds, regarding adolescent suicide.

METHODS: This qualitative study used focus groups to elicit the thoughts of distinct sociodemographic groups. A professional moderator guided the sessions by using a semistructured script. All groups were audiotaped. The transcripts and transcript summaries were analyzed for recurrent themes. The study was performed in community centers and schools in Chicago, Illinois (urban), and the Kansas City, Kansas, area (suburban and rural). A total of 66 adolescents (13–18 years of age) and 30 parents of adolescents participated in 13 focus groups.

RESULTS: Both adolescents and parents recognized adolescent suicide as a major problem, but not for their own communities. All parent and adolescent groups identified many risk factors for suicide. Most adolescents reported drug and alcohol use as risk factors for suicide. However, parents often viewed drug and alcohol use as normal adolescent behavior. Both adolescent and parent groups suggested securing or removing guns if an adolescent was known to be suicidal. All participants requested information about adolescent suicide.

CONCLUSIONS: Adolescents and parents need help understanding that suicide is an underidentified problem in their own communities. Both adolescents and parents are interested in learning more about how to identify and to intervene with a suicidal adolescent. Pediatricians are well positioned to provide this information in the office and in the community. *Pediatrics* 2010;125:221–227

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In the United States in 2006, 1771 children and adolescents 10 to 19 years of age committed suicide, which made this the third leading cause of death in this age group. Firearms (43.1%) and suffocation (44.9%) were the primary means for these suicides.[1] Although the incidence of teen suicide was highest among Native American/Alaska Native adolescents, at 15.4 cases per 100 000, white, Hispanic, and black adolescents had significant rates of 4.7, 3.0, and 2.7 cases per 100 000, respectively.[1] Completed suicides reflect a small (albeit significant) part of the problem. According to the Youth Risk Behavior Survey, ~14.5% of all US adolescents in ninth to 12th grade seriously considered suicide and 11.3% of all youths surveyed had made a plan during that year, which is similar to rates in Illinois and Kansas.[2]

Adolescents frequently are the first to know of a peer's suicidal thoughts but are unsure what to do with the information.[3,4] Responses of adolescents to peer disclosures vary and are related to their gender, knowledge about suicide, personal history of suicidal ideation, and perceptions of mental illness.[5–10] Gould et al[8] found that adolescents with maladaptive coping skills displayed dysfunctional attitudes toward a suicidal friend, whereas those with healthy coping skills were likely to demonstrate help-seeking behaviors. Although adults may consider it imperative that adolescents report at-risk peers to adults, a minority actually do.[4,7] Reasons for teens not reporting to adults include a lack of basic knowledge and self-efficacy, the belief that discussing suicide is taboo, and deference toward their peers' requests for nondisclosure.[3,8]

Youth suicide prevention takes many forms. Education may focus on the recognition of individual risk factors, the importance of disclosure and intervention, and environmental modifications such as removal of lethal means. Firearms are used in >40% of adolescent suicides,[1] and safely storing household firearms significantly decreases firearm-involved suicide rates for adolescents <20 years of age.[11] It is difficult to assess whether family members appreciate this environmental risk.

Because a successful suicide prevention program should reflect the attitudes and beliefs of those to whom the intervention is targeted, we set out to gather information for better understanding of what interventions might be perceived as most effective. Focus groups were used because of their ability to explore efficiently the attitudes and beliefs of participants. A few international studies used focus groups previously to study adolescent suicide.[5,10,12]

The primary goal of this formative research study was to describe the attitudes and beliefs of adolescents and parents of adolescents, from a variety of backgrounds, regarding adolescent suicide. Specifically, we sought to understand their perceptions of risk, predictability, and preventability of teen suicide. Furthermore, we explored what participants thought would be helpful for the prevention of adolescent suicide.

METHODS

Participants

In 2006, participants were recruited through stratified (urban, rural, or suburban) sampling through Chicago Youth Programs, Centro Romero community center (Chicago, IL), Mill Valley High School (suburban Kansas City, KS), and Basehor Linwood High School (rural Kansas). Eligible subjects included children 13 to 18 years of age and parents/guardians of children 13 to 18 years of age. Flyers were posted at the centers and schools, and a liaison from the organization assisted with the identification of volunteer participants through e-mail messages, meetings, and after-school programs. All individuals who arrived at the focus group locations and met the eligibility requirements participated. Four distinct sociodemographic groups (urban black, urban Hispanic, suburban white, and rural white) were identified; the 2 urban groups were from Chicago, and the rural and suburban groups were from the Kansas City area. Each participant received a $20 gift card for participation. Each adolescent and parent/guardian gave written consent for participation. Institutional review board approval was obtained from Children's Memorial Hospital (Chicago, IL) and Children's Mercy Hospital (Kansas City, MO).

Focus Groups

A professional moderator conducted semistructured sessions by using a discussion guide developed by the project team (Appendix 1). A bilingual interpreter assisted with the urban Hispanic focus groups. Focus groups were held in community centers and schools the participants routinely attended. Separate focus groups with adolescents (13–18 years of age) and parents of adolescents were conducted in each location. The adolescent groups were gender-specific, whereas parent groups were of mixed gender.

Before the start of each focus group, each participant provided the following information: age, gender, ethnicity, zip code, level of education attained, and, for the parents, ages and number of children. At the beginning of each session, the moderator introduced the project and explained the purpose of the focus group. For each idea discussed, general open-ended questions were followed by probing questions. A pediatrician attended each focus group

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and was available to address participants' concerns. A list of local mental health resources was provided to all participants. Each session lasted 60 to 90 minutes, and all sessions were audiotaped and transcribed.

Analysis

The transcribed data were entered into NVivo 7 (QSR International, Cambridge, MA) for organization of the transcripts, to allow easier ascertainment of recurring themes. All authors reviewed the transcripts to identify response themes for each focus group, as well as the groups as a whole. Similarities and differences among the participants and groups were assessed.

RESULTS

Focus Groups

Eight adolescent focus groups (N = 66) and 5 parent groups (N = 30) were conducted. The focus groups ranged in size from 3 to 11 participants (Table 1). The mean age of adolescents was 16 years, and one half of the adolescents were female; 87% of the parent participants were female, with an average of 3 children. Results of the discussion were grouped into topic areas, that is, adolescent suicide risk, predictability, preventability, environment, resources, and training.

TABLE 1 Demographic Characteristics

Adolescents	
Suburban white	
Gender, *n*	
Male	8
Female	9
Age, mean (range), y	16 (15–17)
Rural white	
Gender, *n*	
Male	9
Female	10
Age, mean (range), y	16 (14–18)
Urban black	
Gender, *n*	
Male	10
Female	7
Age, mean (range), y	16 (13–17)
Urban Hispanic	
Gender, *n*	
Male	6
Female	7
Age, mean (range), y	16 (14–18)
Parents	
Suburban white, *n*	8
Female, *n* (%)	7 (88)
Age, mean (range), y	45 (37–50)
High school graduate, %	100
Some college, %	50
No. of children, median (range)	3 (2–6)
Rural white, *n*	7
Female, *n* (%)	7 (100)
Age, mean (range), y	48 (38–56)
High school graduate, %	100
Some college, %	100
No. of children, median (range)	3 (2–4)
Urban black, *n*	12
Female, *n* (%)	9 (75)
Age, mean (range), y	38 (23–55)
High school graduate, %	75
Some college, %	50
No. of children, median (range)	4 (1–12)
Urban Hispanic, *n*	3
Female, *n* (%)	3 (100)
Age, mean (range), y	36 (37–40)
High school graduate, %	33
Some college, %	0
No. of children, median (range)	3 (2–4)

Risk

Adolescents

Views of the pervasiveness of adolescent suicide varied among groups. The urban Hispanic adolescents reported that they did not think that adolescent suicide was a large problem. One urban Hispanic adolescent said, "They think about it . . . but it's just for a little while and then it goes away." Urban black adolescents in the study reported that adolescent suicide was a large problem but not for their peers. One urban, black, male adolescent stated that the problem was one of "a lot of white people in distress, killing themselves." Suburban and rural white adolescents reported that adolescent suicide was a problem somewhere else. Many adolescents thought that suicide attempts might be used to gain attention. However, several groups reported a belief that many actions (eg, extreme risk-taking and dangerous driving) taken by adolescents may represent suicidal gestures, although they may not be perceived initially as such.

Parents

The urban black and rural and suburban white parent groups reported that adolescent suicide was a problem, but no groups acknowledged it as a problem in their own community. One black parent commented, "It seems like it's more of a, you know, race thing. It seems like you hear about that more with the white than with the black." The consensus of the urban Hispanic parent group was that suicidal thoughts were common but acting on them was not.

Predictability

Adolescents

As a whole, adolescents reported that they could identify changes in behavior predictive of suicide in their peers. Identified changes included losing interest in activities, changing friends, withdrawing from social interactions, and exhibiting mood changes. All of the female adolescent groups revealed a belief that "cutting" is a behavior suggestive of suicidal thoughts. A few adolescents in each group reported that it would be difficult to predict that an individual was suicidal.

All adolescent groups indicated that some suicidal adolescents hide their symptoms and that it was likely that many of their peers considered suicide without outward signs. Participants thought that adolescents who did not discuss their suicidal thoughts were more likely to complete suicide successfully.

Overall, adolescent groups thought that suicidal thoughts often were the result of too many stressors and not enough support. The adolescent groups noted the following as significant contributors for suicide: mental illness, low self-esteem, lack of family support, and negative life experiences.

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Distinct for the urban adolescents were descriptions of gang violence and trouble with law enforcement as negative life experiences. One black adolescent girl said, "I think that the only reason they want to kill themselves is like some had a real, real, bad experience in their life and they look like, well, I already feel like I'm dead." Most adolescent groups identified peer pressure and romantic relationships as significant contributors to suicidal thoughts. Several groups of adolescents cited breakdown of family relationships and lack of parental understanding as contributors to suicide. Family disruption, for example, divorce (suburban settings) and jail or death (urban settings), was discussed.

All of the male adolescent groups expressed the belief that drug and alcohol use could be indicative of suicidality. Some identified substance use as a form of self-medication or self-harm. Female adolescents were more varied in their opinions of drug use and alcohol use and how they contribute to suicide. One adolescent girl commented that "some people use [alcohol] to escape everything, to stop their pain." Another adolescent thought that drinking was socially acceptable and therefore not predictive of suicide. The urban Hispanic adolescents reported that use of drugs and/or alcohol was normal among adolescents, and they did not see a relationship between suicidal ideation and substance use.

Parents

Parents in the study generally agreed that suicide is difficult to predict. One rural white parent said, "They are changing and one minute to the next, someone says something bad to them and it just clicks in their mind 'I can't take it anymore' and it just happens." Many parents expressed concern regarding adolescents who do not display any signs of suicidality.

Parents were also concerned about adolescents who lack support at home. One urban black parent said, "Maybe they have a parent they want to talk to but don't really have the time for them . . . they think that suicide is the only option."

All of the parent groups agreed that suicide could be linked to depression and other psychological problems. In particular, they named changes in behavior and mood, loss of interest in activities, withdrawal from social situations, changes in friends, and reckless behaviors as potentially predictive of suicide.

All parent groups described the pressure to "fit in" as a stressor for adolescents. A rural white parent commented, "I think everyone always looks at the kids that are not the popular kids; they think those are the ones most likely to commit suicide, but I think it's the popular ones because they have more pressure on them." Participation in sports was viewed as important by the rural parent group. Parents also described romantic pressures as possibly contributing to suicidal behavior.

The parent groups described negative life experiences as contributing to adolescent suicide. One urban black parent suggested a series of experiences, "They might have a parent that's on drugs; they may have peer pressure that's going on in school . . . kids that have been beat up all the time and picked on." Urban black parents described not meeting adolescents' basic needs (ie, food and clothing) as contributory. Suburban white parents cited breakdown of the family unit as an issue. Many parents stated they thought that drug or alcohol experimentation was noncontributory and commonplace. This nonchalant attitude was illustrated by a suburban white parent who commented that "some parents smoke pot with their kids or allow their kids to drink."

Preventability

Adolescents

Many girls in each of the female adolescent groups thought they could help prevent suicide in a peer, especially if they could identify the situation early. Cited interventions included talking to the friend, talking to adults, and helping the individual find professional help. They indicated that they would most likely talk to their own parents, but they expressed concern about talking to the friend's parents, who might be part of the underlying problem.

The views of the male adolescent groups about preventing a friend's suicide covered a broad spectrum. Some urban black male adolescents' attitudes were fatalistic and permissive. For example, one teen said, "You can't make nobody live, if they don't want to live, what you gonna make them for?" All adolescent groups acknowledged that it would be more difficult to prevent the suicide of someone who hides his or her symptoms well.

Parents

The parents in this study generally endorsed the belief that they could assist in suicide prevention for a suicidal adolescent, specifically if the child was one of their children's friends. The adults indicated that suicidal adolescents needed professional help and close adult supervision. One rural white parent said, "It's just going to come down to creating that safety net of social support in some way, whether at school, the community, or the kid's parents." In contrast, one of the urban Hispanic mothers said, "I think that the solution is often found with the home."

Environment (Adolescents and Parents)

In general, all groups reported that, if there was a suicidal adolescent in the home, then significant changes to the environment would be required. For in-

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stance, several groups discussed a need for increased supervision of the at-risk adolescent. However, some male adolescents expressed concern that providing too much supervision might upset the adolescent more.

Although members of each group stated that they thought that guns needed to be secured within the home of a suicidal teen, most groups stated a belief that there are several ways in which adolescents can commit suicide (eg, medications or knives) and teens who are serious about committing suicide will find the means. One teen pointed out, "Access and convenience increase the chance that someone would commit suicide." Those in rural and urban settings discussed how common guns are in the home. Rural participants were most likely to discuss the presence of guns for hunting, whereas urban participants discussed the need for guns to provide protection.

Resources and Training

Adolescents

Overall, adolescent participants reported needing more readily available resources, including additional training in identifying risk factors and intervention strategies. Adolescents were particularly interested in peer education, because they thought they would be the first to identify a problem and would be the ones most likely to be called on by a friend. Adolescents reported that the testimony of a peer who had been suicidal in the past would be most effective in raising awareness. Some groups also expressed an interest in hearing from experts and in multimedia training.

Parents

The urban black parents specifically indicated that everyone in the community should be trained, because it is difficult to determine to whom adolescents will turn. Some parents expressed concern that discussing suicide might put the idea in the minds of adolescents. In general, participants thought that training and awareness should be widely available for community members, including parents, teachers, counselors, community leaders, and adolescents.

DISCUSSION

This research facilitated an in-depth study of the attitudes and beliefs about adolescent suicide held by adolescents and their parents, representing multiple sociodemographic groups. Both adolescents and parents identified adolescent suicide as a major problem but did not recognize it as a problem in their own communities. Clinical guidelines from the American Academy of Pediatrics recommend that pediatricians address and evaluate risk for all suicide attempts.[13] However, only 2% of suicide attempts receive medical attention; therefore, pediatricians should recognize suicide as a health issue worthy of screening during regular visits.[2] All parent and adolescent groups correctly identified many of the known risk factors for adolescent suicide, including mental illness, alcohol and substance abuse, relational or social loss, and hopelessness.[14,15] However, it is concerning that many of the parents reported regular drug and alcohol use as being a normal part of adolescent development, rather than problematic behaviors. Pediatricians need to be aware of how parents and adolescents think about substance use and abuse, to frame their anticipatory guidance most effectively.

Both adolescent and parent groups suggested that guns be secured or removed if an adolescent is known to be suicidal. Parent groups suggested close monitoring of adolescents who are experiencing suicidal thoughts; however, parents in all groups in this study acknowledged that they might not be able to identify a suicidal teen. This uncertainty suggests that pediatricians should routinely advise families regarding the proper storage of firearms.

All groups identified the need for more resources and information about adolescent suicide. Suicide prevention programs aimed at developing adolescents' problem-solving, coping, and cognitive skills, rather than curricula limited to raising awareness of suicide, show promising results.[15] Although general community interventions have not been tested, "gatekeeper" training of teachers and other school personnel seems promising.[15]

Furthermore, pediatricians can help parents understand the importance of removing lethal means from their homes and monitoring their adolescents. Resources such as the American Academy of Pediatrics Connected Kids program may assist with this goal (Table 2). Those who develop and implement suicide prevention strategies should ask the families in their communities about the unique beliefs and experiences of the community, to ensure that interventions are culturally appropriate and effective.

This was a qualitative study with a diverse sample that sought to elicit a wide range of responses. These qualitative methods were not intended to be representative of the specific populations, and they were not designed to determine the exact proportions of adolescents and parents who held certain beliefs. The participants were self-selected and might have had nonrepresentative ideas about adolescent suicide. However, these groups provided thoughtful reflections that revealed many common themes and ideas.

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TABLE 2 Resources for Families

Organization	Web Site	Information
American Academy of Child and Adolescent Psychiatry	www.aacap.org/cs/root/facts_for_families/teen_suicide	Facts for families, available in multiple languages
American Academy of Pediatrics	www.aap.org/advocacy/childhealthmonth/prevteensuicide.htm	Questions for parents to assess their teens
National Alliance on Mental Illness	www.nami.org/Content/ContentGroups/Helpline1/Teenage_Suicide.htm	Additional resources and book suggestions for families
National Suicide Prevention Lifeline	www.suicidepreventionlifeline.org	24-h hotline; 1-800-273-TALK (8255) (English) or 1-888-628-9454 (Spanish)

CONCLUSIONS

Both adolescents and parents of adolescents need help to understand better the underidentification of suicide in their own communities. Pediatricians should regularly screen all adolescents in their offices and should encourage families to be open to discussing depression and suicide. All groups were interested in additional training on how to identify and to intervene with a suicidal adolescent. Pediatricians are well positioned to assist, in both office and community settings, in identifying resources in the community.

Future studies of adolescent suicide prevention might seek to measure the ability of adolescents and parents to identify and to reduce risk factors for adolescent suicide. In addition, studies might assess the capacity of community-based organizations for skills training in the identification of and initial intervention for suicidal adolescents. Given the varied responses observed among ethnic and socioeconomic groups, future studies to evaluate approaches to prevention and education specific to individual demographic groups are warranted.

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APPENDIX 1 Question Guide Used for Focus Groups

General information about adolescent suicide
- When you hear the words "teen suicide," what comes to mind?
- Among all the problems teenagers have, how big of a problem is suicide?

Predictability
- What do you think about the predictability of suicide among teenagers?
  - Probe: beliefs, developmental knowledge, and reasons why
- What ways are there to predict teen suicide? Who is at risk?
  - Probe: personality changes, behavioral indicators, drugs, and alcohol

Preventability
- What do you think about how preventable teen suicide is?
  - Probe: ways to prevent suicide among young people
- What would you say or do to help a suicidal teen?
  - Probe: talking to the parent of the suicidal teen

Environment
- What are your thoughts about guns in the house and suicide? What do you think the presence of a gun in the house does to the risk of suicide?
- If you had a suicidal teen in the home, what about the home environment or routines would you change?
  - Probe: securing guns, medicines, schedules, and supervision

Resources
- What other resources do you have access to that would be helpful for the suicidal teen?
  - Probe: in the community and in the family

Training
- Do you think there needs to be more education about recognizing and intervening with potentially suicidal teens?
  - Probe: Who should be educated? Where should it be offered?

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