Background Paper **BP-236E**

TEEN SUICIDE

Andrea Shaver
Political and Social Affairs Division

August 1990

Library of
Parliament

Bibliothèque
du Parlement

**Parliamentary
Research
Branch**

The Parliamentary Research Branch of the Library of Parliament works exclusively for Parliament, conducting research and providing information for Committees and Members of the Senate and the House of Commons. This service is extended without partisan bias in such forms as Reports, Background Papers and Issue Reviews. Research Officers in the Branch are also available for personal consultation in their respective fields of expertise.

CE DOCUMENT EST AUSSI PUBLIÉ EN FRANÇAIS

TABLE OF CONTENTS

PAGE

INTRODUCTION 1

A. Reasons 2

1. Gender Differences 2
2. Cultural Differences 4
3. Cultural Differences: Quebec 5
4. Suicide Clusters 5

B. Prevention 6

1. Recognizing the Symptoms 6
2. Strategies That Work 6
3. Culturally Specific Approaches: Natives 8

CONCLUSION 8

BIBLIOGRAPHY 9

CANADA

LIBRARY OF PARLIAMENT
BIBLIOTHÈQUE DU PARLEMENT

TEEN SUICIDE

INTRODUCTION

Canadian suicide rates greatly increased in the 1960s and 1970s and, while they have levelled out in the 1980s, they are still at the highest level in Canadian history. Between 1960 and 1978, the overall suicide rate rose from 7.6 per 100,000 population to 14.8, according to Statistics Canada figures. During the last decade, the suicide rate, though relatively stable, has been about double the rate throughout most of the period from1921 to 1961 and well above previous highs recorded during the Depression of the 1930s. It is important to remember that the actual number of suicides in Canada may be under-reported. A death is only certified as a suicide by medical and legal authorities when the victim's intent is clearly proven.

The federal government moved to address the suicide problem by appointing a National Task Force on Suicide in Canada in 1980. Its report was made public in 1987. Though the statistics used are from 1985 at the latest, and more often earlier, the study is the most comprehensive examination of the phenomenon ever done in Canada. Seven population groups were identified by the Task Force as being at high risk; one of these was young people. While males aged 20-24 constitute the age group with the most significant rise in suicide deaths in the past 20 years, marked increases have been noted in the 15-19 age group, again most significantly among males. The report describes and evaluates a range of prevention, intervention and follow-up programs, and makes a number of recommendations having to do not only with the determinants of suicide but with the means of preventing it. No major federal policy initiatives have resulted from the report. It is not the aim of this paper to review the findings of the Task Force report but rather to comment on changes in dealing with certain aspects of the teenage suicide phenomenon that have taken place since the Task Force research and have been discussed in the literature since 1987.

Though the suicide rates are higher in Canada than in the United States, Canadian statistical trends correspond for the most part with the American; therefore, some American

studies will be cited in this paper in an attempt to focus more precisely on suicide among teenagers.

A. Reasons

There are no definitive explanations of why more teenagers are committing suicide than ever before. Suicide is multi-dimensional behaviour and difficult to define in any essential way.

The foremost theoretician on suicide, Emile Durkheim, defined three types. The first is altruistic suicide, where the individual is so closely integrated into a group or society that he or she will commit suicide for the perceived benefit of the group. Examples would be the Japanese kamikaze pilots of World War II and the mass suicide at Jonestown.

The second type is egoistic suicide; this is characterized by a strong value system, weak group integration and an overpowering sense of personal responsibility. The group itself is not strong enough to provide the individual with a sufficient source of outside support and strength and the society is not sufficiently integrated to be able collectively to mitigate the individual's feeling of responsibility and guilt for moral weakness and failure.

Anomic suicide, the third type of suicide identified by Durkheim, is not characterized by a strong value system. It results from not being properly integrated into a system of cultural values and thus seeing social norms as meaningless. The characteristic feelings of isolation, loneliness and personal confusion noted in this type of suicide are often brought on by a major disruption in one's way of life, such as the death of a parent or a move to a new home far from friends.

Anomic suicide might be thought to provide the best explanation for the phenomenon of teenage suicide, as it hinges on experiences closely associated with adolescence. Subtle distinctions exist, however.

1. Gender Differences

No matter what the age group, being male has been found to raise the odds of suicide in Canada. It should be noted, however, that maleness is only significant in terms of completed suicide, with parasuicide (attempted suicide) being up to three times as common among females as males. There are ten times as many suicide attempts as there are deaths, but

males are six times more likely to die of suicide than are females. This has been found to be a cross-cultural phenomenon.

Psychologist Antoon Leenaars, president of the Canadian Association for Suicide Prevention, says the reasons for this gender disparity are more sociological than psychological.(1) He explains that males are socialized to hide their feelings and deny pain if they are "to be men." This emphasizes personal responsibility for not fitting into the dominant male culture. Male culture places no great emphasis on mutual support during adolescence, but rather thrives on competition. It is a culture, too, which has been weakened by the sexual revolution and is in the process of change. These factors show that suicidal impulses in young males have more to do with the egoistic model than the anomic model.

Females, on the other hand, tend to follow the anomic model. In studies carried out to determine why teenage girls and women make so many suicide attempts and yet experience so few suicide deaths, theorists have gone much further than Durkheim. Self-in-relation theory, which is applied in researching females and depression, is helpful in illuminating gender differences in suicidal behaviour. Current literature consistently links the primacy placed by females on relationships with factors influencing suicidal behaviour. Thus, stress resulting from an inability to deal with interpersonal conflicts is more likely to be a factor for females than for males. This theory focuses on four common processes which, when exaggerated, underlie women's suicidal attempts: the concepts of vulnerability to loss, inhibition of anger, inhibition of action and aggression and low self-esteem. Rather than perceiving these as weaknesses, as in traditional theory which views the male experience as the norm, self-in-relation theory looks at these behaviours as sources of strength based on a female norm. By examining the normative experience of females, greater understanding of the gender differences in suicidal behaviour is emerging.

Another theory used to explain the gender differences between suicide attempts and suicide completions hinges on the methods of attempted suicide used. Teenage girls tend most often to use drugs while boys use more instantaneously lethal methods, such as firearms. Such differences are changing, according to American sources. The Centers for Disease Control noted that in 1970 fewer than one-third of the suicides by women aged 15 to 24 were carried out

---

(1) Burt Dowsett, "Young Men, Senior Males Form Most Suicidal Groups," in *London Free Press*, 12 June 1990.

with a firearm, while in 1984 firearms were used in a little more than half of the female suicides in that age group. While, in 1970, 42% of the young women who killed themselves used drugs, by 1984 this percentage had dropped to 19%. Sociologist James Mercy expects these trends to continue because of the easy availability of firearms in the United States and the increasing difficulty of obtaining lethal types of barbiturates.(2)

A controversial theory for explaining the gender difference put forward by psychologist Lee Salk of Cornell University Medical School drew a link between birth trauma and later suicide. He observed that infant mortality rates begin dropping substantially around fifteen years, before teenage suicide rates begin escalating. Pointing out that male babies suffer from more birth complications than females, he went on to document the three common denominators that turned up repeatedly among the suicides he studied: respiratory distress for over one hour at birth, lack of prenatal care before the twentieth week of pregnancy, and chronic ill health of the mother during pregnancy. He even went so far as to demonstrate a correlation between methods used in suicide attempts and the type of intervention used at birth.

The hypothesis was pursued by doctors in Sweden, who found that suicide was more closely associated with birth trauma than with any other of the 11 risk factors for which they tested, including such socioeconomic variables as parental alcoholism and a broken home. This theory continues to be very controversial among the medical community, where obstetrical control and intervention are increasing, rather than decreasing as these scientists advocate.

2. Cultural Differences: Comparison with the United States

A recent comparison of suicide rates in the U.S. and Canada found that the teen suicide rate among Canadian males is 57% higher than in the United States. Antoon Leenaars of the Canadian Association for Suicide Prevention attributes this to the cultural theory that Canadians are more repressed than Americans; the suggestion is that Canada was founded as a colony based on the British values of Queen and religion, while the United States was built by aggressive, gun-toting pioneers who fought their way westward crushing all obstacles in their path. "Because of that," says Leenaars, "it has been suggested that in the U.S. they kill each other. In Canada we kill ourselves."(3) While simplistic on their own, the observations of

---

(2) Judy Folkenberg, "Guns and Gals," in *Psychology Today*, July/August 1988.

(3) "Teen Suicide," in *Windsor Star*, 7 April 1990.

Dr. Leenaars suggest a cultural dimension to suicidal behaviour that may be useful to consider in prevention techniques, as will be discussed later with respect to Native people.

3. Cultural Differences: Quebec

Quebec has the highest rate of teen suicides of all the Canadian provinces, as well as one of the highest rates in the world. Dr. Mounir Samy, founder and director of Montreal General Hospital's adolescent crisis intervention team, citing the Quiet Revolution and family breakdown, argues that the social upheaval in Quebec since the 1960s has affected troubled teenagers by giving them nothing stable to fall back on. Another contributor, Samy suggests, is the "suicide option" our society offers. "We are a society that values the quality of life rather than its quantity… Life is [seen by some teenagers as] not worth living if you cannot guarantee its quality."(4) The cultural aspect of suicide behaviour can be examined both broadly and specifically. While this aspect is only part of the picture, it is nonetheless an essential element in the search for effective solutions.

4. Suicide Clusters

While the increase in suicides has levelled out in recent years, the number of "cluster suicides" is on the increase and has served to focus public attention on teenage suicide in Canada. In Lethbridge, Alberta, three youths committed suicide within three months of each other and a similar tragedy occurred in Antigonish, Nova Scotia. While some suspected Satanic cult influences in the Lethbridge case, there has been no substantial evidence of this. Teenagers themselves say media focus on the possible influence of cults, heavy metal music or music videos are just attempts by adults to relieve their own feelings of guilt and to avoid listening to the real problems of teens. While reasons for the increase in cluster suicides are inconclusive, it is safe to say that young people who do not find solutions to their problems from family, doctors or teachers, look to their peers for assistance.

Some studies, such as a 1990 study by Simon Davidson, director of psychiatric research at the Children's Hospital of Eastern Ontario, say that half of all teenagers think about suicide. Dan Wiseman, head of social services for the Ottawa Board of Education has noted, however, that only 10 to 12% of those students actually attempt suicide, while only 1 to 2% die.

---

(4) "Teen Suicide Rate Linked to Quiet Revolution," in *Montreal Gazette*, 13 May 1988.

Wiseman, who helped implement the Ottawa Board's in-house teen suicide prevention program, says that, because teenagers lack experience in solving problems and dealing with stress, suicide becomes a viable alternative.[5]

B. Prevention

1. Recognizing the Symptoms

According to the London/Middlesex branch of the Canadian Mental Health Association, which has been very active in teen suicide prevention programs, there are several warning signs of suicidal intent: depression; statements that show a preoccupation with dying; drastic behaviour or mood swings; lack of interest in future plans; making final plans; previous attempts (80% of people who kill themselves have attempted to do so before); sudden improvement after a period of depression; and self-destructive behaviour.[6]

Anxiety, isolation, depression, drug abuse, delinquency and family breakdown can all be implicated, either separately or in combination. The importance of family relations is noted by American therapists, who point out that family therapy is on the decline, with parents being increasingly unwilling to be involved in the therapy of their children.

Of teenagers who eventually attempt suicide, 80% show up at a doctor's office before doing so. The teenagers complain of symptoms, such as insomnia, fatigue or problems at school, that should sound alarm bells but whose significance may be missed by the doctor.[7] This finding has diverted the focus of prevention techniques away from the family unit and the medical profession and toward the schools.

2. Strategies That Work

Bruce Connell, a consulting psychologist for the Board of Education in London, Ontario, concluded from his survey of the literature on the subject of teen suicides that 95 to 97% of them could be prevented.[8]

---

(5) John Ibbitson, "Experts Rap Report on Teen Suicide," in Ottawa Citizen, 17 January 1989.

(6) According to Burt Dowsett in "Suicide: Recognizing the Symptoms," in *The London Free Press*, 12 June 1990, the death of a parent, particularly a mother, increases the risk of a suicide attempt 600 times.

(7) Richard Sutherland, "Teenage Suicide Epidemic in Canada," *The Financial Post*, 22 February 1990.

(8) Dowsett, "Suicide: Recognizing the Symptoms" (1990).

Frank Trovato's study of the effects of age, period and cohort examined Canadian statistics from 1921-25 to 1981-85.(9) It concluded that divorce of parents and urbanization increase the likelihood of committing suicide, while the effect of religious secularization, although present, does not reach statistical significance. This study confirms that suicide is mainly an age-specific phenomenon, with period and cohort being of limited relevance for the substantive understanding of suicide in Canadian society.

In the search for prevention techniques to be implemented through the school system, Dr. Barry Garfinkel, director of child and adolescent psychiatry at the University of Minnesota, has designed questionnaires eliciting information on depression, which he has administered to 15,000 students annually for several years. A student scoring positive on the questionnaire is sent to a guidance counsellor or school psychologist. This strategy has gained approval in Canada, specifically in Quebec, where the problem of teenage suicide is particularly acute.

Another successful tool has been peer-group discussion groups. Particularly in view of the rise in "copycat" or suicide clusters, this method is seen as a crucial aspect of prevention. When a suicide occurred at A.B. Lucas Secondary School in London in October 1987, the student's friends and a guidance teacher formed a breakfast club to focus some of their grief into positive programs that would help students. The club has grown to 260 students and branched out into orientation programs that help Grade 8 students to make the transition from junior high to high school.

For more effective program planning and management at suicide prevention centres, the Greater Vancouver Mental Health Service has over the past ten years developed a computer information system with the input of counsellors, researchers, community agencies, a clinical consultant and other professionals. The system, which is reviewed annually, was designed to meet practical needs in ongoing counselling, long-term planning and evaluation. The information collected is published in report form and used in public education activities. It should be noted that confidentiality is built into the system.

The National Task Force Report of 1987 included a proposed educational program for school personnel and students; model suicide intervention services for hospitals,

---

(9) Frank Trovato, "Suicide in Canada: A Further Look at the Effects of Age, Period and Cohort," in *Canadian Journal of Public Health*, Vol. 79, No. 1, January/February 1988.

communities and Native people; and an Alberta model for a systematic approach to suicide prevention.

3. Culturally Specific Approaches: Natives

Another identifiable risk group is made up of Native Canadians. The incidence of suicide among Native teenagers is often ten times that among their white counterparts. While it is not within the scope of this paper to examine the Native situation in detail, the success of culturally specific prevention methods used in some communities is worth noting.

Just as suicide in Native communities is a distinct phenomenon, so are the methods these communities use to deal with it. Non-Native methods of education and prevention tend to rely on facts, while Natives use story-telling as a means of giving information about suicide. The technique was demonstrated in an internationally acclaimed radio program called "Kill the Feelings First" developed by George Tuccaru, a Native employee of CBC North in Yellowknife. In this program, stories stimulate the audience to examine various questions in the search for resources with which to cope. The challenge to mental health service planners in Canada is threefold: Are they willing to look at traditional Native health processes as good resources for mental health? Will they trust Natives to develop their own methods and approaches? Will they be able to see Native mental health from a spiritual, though not necessarily religious, perspective? The National Task Force on Suicide in Canada recommended that prevention strategies for Native people should be culturally oriented.

Native teenagers in Grande Cache, Alberta, formed a peer support group following the suicide of a 16-year old Native youth who had lived in a number of white foster homes since the age of nine.(10) While Native community leaders saw this initiative as an important first step they stressed the need to improve family communication and to deal with the problems of alcoholism, violence and sexual abuse found in many Native families.

CONCLUSION

Suicide has been related to lack of social integration, feelings of "alienation" in the population, transience, and rapid changes in values, income and lifestyle. Poor job prospects,

---

(10) Gerry Gee, "Teens Meet Suicide Issue Head On," in *Windspeaker*, 28 July 1989, p. 13.

families in a state of flux, and changing social and moral values could all contribute to high youth suicide rates in the population as a whole. It is important to realize that suicidal behaviour is not necessarily linked to mental health problems and that unemployment and alcoholism are not widespread problems among suicidal teenagers themselves.

While the reasons for suicide are complex and difficult to define, the experience of adolescence brings unique problems to this high-risk age group. Author Marion Crook interviewed a number of teenagers in British Columbia who had attempted suicide. Common denominators that emerged were problems in their family situation and low self-esteem as well as the fact that they had not been helped in their contact with teachers, doctors or other professionals. The pressure to excel, which is not only perpetuated by parents and peers but pervades television programming and commercial advertising, was found to add to the anxiety of adolescence. Skills for coping with these problems and sympathetic assistance from parents, teachers, doctors, other teenagers or television, are essential. The complexity of the issue must not discourage community or government agency efforts to deal with a problem that is responsible for more adolescent deaths in Canada than anything except accidents.

BIBLIOGRAPHY

Beneteau, Renée. "Trends in Suicide." *Canadian Social Trends*, Statistics Canada, Ottawa, Winter 1988 edition.

Corr, Charles A. and Joan N. McNeil. *Adolescence and Death*. Springer Publishing Company, New York, 1986.

Crook, Marion. *Every Parent's Guide to Understanding Teenagers and Suicide*. Self-Counsel Press, Vancouver, 1988.

Crow, Gary A. and Letha I. Crow. *Crisis Intervention and Suicide Prevention*. Charles C. Thomas, Publisher, Springfield, Illinois, 1987.

Curran, David K. *Adolescent Suicidal Behavior*. Hemisphere Publishing Corporation, Washington, 1987.

Deats, Sara M. and L.T. Lenker. *Youth Suicide Prevention*. Plenum Press, New York, 1989.

Hawton, Keith. *Suicide and Attempted Suicide among Children and Adolescents*. Sage Publications, Beverly Hills, California, 1986.

Hodgson, Maggie. " 'Kill the Feelings First': Applying Traditional Methods of Mental Health Education in a Radio Broadcast on Suicide Prevention." *Canada's Mental Health*, September 1986.

Hunter, David G. "Suicide Management Committee: Yorkton's Innovative Community Response to Teen Suicide." Canada's Mental Health, September 1986.

Klerman, Gerald L., editor. *Suicide and Depression among Adolescents and Young Adults*. American Psychiatric Press, Inc., Washington, 1986.

Peck, Michael L., N.L. Farberow and R.E. Litman, editors. *Youth Suicide*. Springer Publishing Company, New York, 1985.

Peters, Ron. " A Computer Information System in a Suicide Prevention Centre." Canada's Mental Health, September 1986.

Polly, Joan. *Preventing Teenage Suicide*. Human Sciences Press, Inc., New York, 1986.

Richman, Joseph. *Family Therapy for Suicidal People*. Springer Publishing Company, New York, 1986.

Russell, Anita and Karen Rayter. *Suicide*. Peguis Publishers Limited, Winnipeg, 1989.