ADOLESCENT SUICIDE: IS THERE ANY HOPE?

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I. Introduction: The Problem of Suicide

Once again the tragedy of adolescent suicide hits the news. On April 3rd 2012, in the Jackson Sun News the article read “Riverside’s Gant found dead; School, Community mourn loss of teammate” (written by Brandon Shields). The Riverside High School senior Stephen Gant was found dead on Tuesday afternoon from an apparent suicide by a self-inflicted gunshot wound.

The Sherriff’s Office was called sometime around 12:30PM by a 911 caller stating that a man was walking on Goodwin Road with a gun and shouting threats of suicide. Officer Chief Deputy Nick Weems stated “We found the body of Stephen Gant about 30 feet from the roadway with a gunshot wound. We do believe at this time that it was self-inflicted; however we will continue to investigate to look at other possibilities to make sure it was suicide”. Later reports conclude that it as a gunshot wound to the head.

Stephen Gant seemed to have everything going for him. He was an A student at the high school, a standout baseball pitcher, was a Vanderbilt University baseball signee, was named The Jackson Sun Baseball Player of the Year for the past three seasons, and was projected to be a number one draft pick in next month’s MLB draft.

The latest facts and figures from the Centers for Disease Control and Prevention reported that there were 36,909 suicides in 2009. With this rise in suicide it is the tenth leading cause of death in the United States. The rate of suicide has been increasing each year since 2000 with a small dip in 2003. The reality is that this is the highest rate in suicide in fifteen years.

Here are some of the facts of suicide as seen by the American Foundation for Suicide Prevention:

- Every 14.2 minutes someone in the United States dies by suicide.
- Nearly 1,000,000 people make a suicide attempt every year.
• 90% of people who die by suicide have a diagnosable and treatable psychiatric disorder at the time of their death.
• Most people with mental illness do not die by suicide.
• Recent data puts yearly medical costs for suicide at 100 million (2005).
• Men are nearly 4 times more likely to die by suicide than women. Women attempt suicide 3 times as often as men.
• Suicide rates are highest for people between the ages of 40 and 59.
• White individuals are most likely to die by suicide, followed by Native American peoples.

There are many misconceptions about suicide. Suicide Awareness Voices of Education or better known as SAVE states the following as the Top 5 Common Misconceptions:

• People who talk about suicide won’t really do it. False- Almost everyone who commits or attempts suicide has given some clue or warning.
• Anyone who tries to kill him/herself must be crazy. False- Most suicidal people are not psychotic or insane; most likely upset, grief-stricken, depressed, or despairing.
• If a person is determined to kill him/herself, nothing is going to stop him/her. False- Even the most severely depressed person has mixed feelings about death, and most waiver until the very last moment between wanting to live and wanting to end their pain.
• People who commit suicide are people who are unwilling to seek help. False- Studies of adult suicide victims have shown that more than half had sought medical help within six months before their deaths and a majority had seen a medical professional within 1 month of their death.
• Talking about suicide may give someone the idea. False- You don’t give a suicidal person ideas by talking about suicide. The opposite is true- bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.

To dispel more of the myths that surround adolescent suicide authors David Cox and Candy Arrington in their book “Aftershock Help, Hope, and Healing in the Wake of Suicide” propose a True/False quiz. I ask you to answer the following True/False questions:
Adolescent Suicide

1) Most suicides occur without warning. T___ F___
   Answer: False - At some point prior to a suicide there was some sort of gesture that took place before the act. It could be any of the following: withdrawal, moodiness, depression, drug/alcohol abuse, eating disorders, threats, or giving away personal possessions.

2) The tendency toward suicide is inherited. T___ F___
   Answer: False - Plain and simple there is no genetic predisposition toward suicide. It is important to note though, suicides do tend to run in families.

3) When depression lifts, suicide is no longer a concern. T___ F___
   Answer: False - If a depression does lift the result may be a resolve to go ahead with the suicide.

4) A suicidal person cannot be talked out of it if his/her intent is on dying. T___ F___
   Answer: False - For a person who is wavering on the side of suicide, all that might need to take place to tip the scale to the side of living is a kind, compassionate, listening friend who is compassionate to the needs of the one considering suicide.

5) Only crazy or insane people commit suicide. T___ F___
   Answer: False - A person who thinks about or attempts suicide is not necessarily crazy or insane. It is so easy for negative thoughts, depression, and hardships of life to overwhelm a person to the point of wanting to end their life.

II. Descriptive: “What Is Going On?”

   Samuel was an eleven-year old child referred to the child psychiatry clinic for attempted suicide. He had concocted a mixture of medicines prescribed to his mother- antibiotics, sleeping pills, and aspirins, consuming large quantities of each in an attempt to kill himself. He slept at home for almost two days; when he was finally awakened by his mother, she rushed him to the hospital.

   Samuel lived in an inner-city neighborhood and has been in trouble since the second grade for stealing and breaking into empty houses. In school he has struggled with academic difficulties and was assigned to a special reading resource room for part of each day.
The mother admitted that she drinks heavily and relies on prostitution as a source of income. She has several apparent “Major Depressive Episodes”, but has not been treated for them. Samuel’s father is absent from the picture and has not had any contact with Samuel since his birth. His whereabouts is unknown.

During Samuel’s initial interview he appeared sad and cried at one point with his shoulders shaking. He reported having severe blue periods, the most recent of which had been continuous for the past month. During these periods he thought he might be better off dead. Recently, he has been waking up in the middle of the night and has not been able to fall back asleep. Also, he reported that he has been avoiding his usual neighborhood friends. (Rapport & Ismond, 1996).

Under the guidelines of the “DSM-IV Training Guide for Childhood Disorders”, Samuel’s diagnosis would look like this:

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.23</td>
<td></td>
<td>Major Depressive Order, Single Episode</td>
</tr>
<tr>
<td>312.3</td>
<td></td>
<td>Conduct Disorder, Childhood Onset Type, Mild</td>
</tr>
<tr>
<td>315.0</td>
<td></td>
<td>Reading Disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Axis II</th>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>V71.09</td>
<td></td>
<td>No Diagnosis on Axis II</td>
</tr>
</tbody>
</table>

| Axis III    |          | None                                           |

| Axis IV     |          | Problems with primary support group; psychiatric disorder in mother, inconsistent parenting, inadequate income problems related to social environment, adverse social environment, educational and academic difficulties |

| Axis V      |          | GAI=45(current)                                |

(Rapport & Ismond, 1996, pp 211-212)

Even though Samuel’s attempt at suicide was proven unsuccessful, the suicide epidemic has exploded among the adolescent age brackets. Dr. Drew Velting, a psychological science
professor at Ball State University, insists that as the numbers of attempted and successful suicides have steadily increased over the last thirty years, parents need to be aware of the warning signs that can help prevent suicide. (USA Today, 1997).

Dr. Gary Collins lists the following warning signs of suicide in no particular order:

- Talk of suicide
- Evidence of a plan of action for killing oneself
- Feelings of hopelessness and/or meaningless
- Indications of guilt feelings and worthlessness
- Recent environmental stresses (Teicher{1979} indicates that early loss of a parent during the first two years of life, followed by the loss of an important adult during adolescence; acts as a precipitating factor in 70% of adolescent suicides)
- An inability to cope with stress
- Preoccupation with insomnia
- Evidence of depression, disorientation, and/or defiance
- Tendency to be dependent and dissatisfied at the same time
- A sudden and unexplainable shift to a happy, cheerful mood (which often means that the decision to attempt suicide has been made)
- Knowledge regarding the most effective methods of suicide (guns and carbon monoxide work best; wrist slashing is least successful; drug use depends on how much is taken and the type of drug)
- A history of prior suicide attempts (those who have tried before, often try suicide again) (Collins, G.R.1988)

Adolescent suicide is the third leading cause of death among teens in the 15-19 age bracket and the 4th leading cause of death for 10 to 14 year olds. It is now a major health concern. According to the Center for Disease Control there are about 2,000 adolescents taking their lives each year in the United States. According to Dr. Drew Velting, the profile age for the average adolescent suicide is a white male who uses a firearm to kill himself. Males outnumber females five to one in the amount of completed suicides, white females are two times more likely to
attempt suicide often by using less lethal means such as drug or alcohol overdoses (Adults should heed teen warning signs, 1997).

Suicide was the fifth leading cause of years of potential life lost before age 65 years in 1980. During 1980-1992, a total of 67,369 persons aged 25 years or younger committed suicide and in 1993 persons in this age group accounted for 16.4% of all suicides. From 1952 through 1992, the incidence of suicide among adolescent and young adults nearly tripled. One of the National Health objectives for the year 2000 is to reduce the suicide rate for persons aged 15-19 years by less than 25% to 8.2% per 100,000 persons (Center for Disease Control and Prevention, 1995). According to a recent study by the Center for Disease Control it is difficult to determine if they have reached their goal. On September 6th, 2007 the Center for Disease Control reported that suicide rates in American adolescents increased 8% in 2003-2004, the largest jump in 15 years.

Even though the statistics support that the white male is at the greatest risk of teenage suicide, there is new evidence that blacks and homosexual teens are at great risk. According to the U.S. Department of Health and Human Services, youth who are attracted to the same sex (gay and lesbian) are two to three times more likely to attempt suicide than heterosexual children and account for up to 30% of all completed teens suicides (Gibson, 1989). A total of 3,030 blacks aged 10-19 years committed suicide in the United States during 1980-1985. During this period, the suicide rate for blacks aged 10-19 years increased 114%. In 1980, the suicide rate for whites aged 10-19 years was 157% greater than the rate for blacks. By 1995, the rate for whites was only 42% greater than the rate for blacks. Among blacks and whites aged 10-19 years, the suicide rate increased most for blacks aged 10-14 years (233%) compared with a 120% increase for whites. Among black males aged 15-19 years, the suicide rate increased 156% compared with 22% for white males (Center for Disease Control and Prevention, 1998).

III. Interpretive: “Why is this going on?”

A Psychological Profile

When studying adolescent suicide it is critical to be aware of the psychological profile of a suicidal adolescent. When talking about the psychological profile you are referring to the
personality tendencies, mental and emotional states that distinguish suicidal young people from those who are not suicidal. It is important to recognize that not everyone who is suicidal will fit the profile and that some people who may fit the profile may never attempt suicide.

A psychological profile such as this requires incredible data. The data would come from a large-scale, comprehensive study. A research team would give out psychological tests measuring all personality dimensions that are suspected. Then waiting periods over a number of years to see which of the young people in the sample take their own lives. The problem with this strategy in the numbers involved. For the purposes of this thesis paper I will rely on a more fragmented approach, piecing together the findings from many smaller studies.

**Depression**

Depression seems clearly related to suicide. This association makes sense intuitively and clinically. Yet, if you ask are all young people who are suicidal if they are depressed? The answer is no. Looking at the evidence using the Psychological Autopsy Method, Lesage and his colleagues probed into deaths of 75 young men ages 18-35. Based on the interview with friends and family members, the researchers concluded that a major depression was present in nearly 40% of the men before they died (Lesage, Boyer, Grunberg, Vanier, Morissette, Menard-Buteau, & Loyer, 1994). Another study by Greenberg, Stiglin, Finklestein, & Erndt found at least half of those who committed suicide were severely depressed (Journal of Clinical Psychology 1993).

When you move down the age scale to adolescents, you find remarkably similar figures for the incidence of depression. In the psychological autopsy study carried out by Brent’s group in the Pittsburgh area, it was estimated that 40% of the suicide victims had suffered from a major depression. If one added to this presence of dysthymic disorder a long-lasting, less severe depression, the figures rise to 60%. The Psychological Autopsy Method points to depression as a factor in many suicides of young people (Brent, Perper, Goldstein, Kolko, Allan, Allman & Zelenak, 1998).
Walt Mueller provides a helpful list of some common signs and symptoms of adolescent depression:

- Persistent Sadness
- Fluctuation between silent apathy and excited talkativeness
- An inability to concentrate
- A major change in eating and/or sleeping patterns
- Withdrawal from friends and family
- Complaining about headaches and stomachaches
- Severe weight gain or loss
- Decreasing grades and unwillingness to work in school
- Truancy
- Rapid mood swings
- Lack of interest in regular activities (sports, church, music lessons, youth group, etc.)
- Pessimism of helplessness, worthlessness, hopelessness
- Preoccupation with death or suicide (Mueller, 1994, p. 297)

**Hopelessness**

The second building block of a psychological profile of adolescent suicide is hopelessness. Researchers have shown a positive correlation between hopelessness and attempted suicide above and beyond a subject’s depressed state of mind (Marana, Cisler, & Lemerod, 1993). Hopelessness encompasses both an emotional state and a perception of one’s circumstances. The mood may be bleak; the perception is not only that things are terrible, but there is no hope that things will ever get better. The adolescent sees no clear path open that could alleviate the problem and in the worst case, he or she cannot even admit the possibility that there could be ways of making things better.

**Anger**

The third building block of a psychological profile of an adolescent suicide is anger. The research carried out to date that both anger and aggressive behavior are common among
Adolescent Suicide

young people attempting suicide. These tendencies have been noted in the emergency rooms. In a study of adolescents hospitalized for suicide attempts, Maria Gispert observed; “The expression of anger varied considerably. More than one-third admitted throwing objects, fighting, or injuring themselves when angered” (Gispert, Marsh, & Wheeler, 1985, p.64). All of these observations suggest the importance of paying attention to suicidal young people whose behavior is characterized by extreme forms of anger.

**Self Esteem**

The fourth building block of a psychological profile of an adolescent suicide victim is self-esteem. Self-esteem is the way we look and feel about ourselves. Self-esteem has a flavor of evaluation to it. When a person thinks highly of themselves it is said that they have a high-self esteem. When a person has a low opinion of themselves it is said they have a low self-esteem. It is a reasonable theory that a person with a very low self-esteem would be more prone to attempt suicide than would a person with a very high self-esteem.

**Ideation**

The final building block to add to the list of psychological factors that relate to suicide is ideation. By this I mean the way one copes when faced with difficulties. Some people are able to respond more effectively when problems arise and are consequently less likely to be overwhelmed by them and react by entertaining suicidal ideas.

There are many ways of coping when one is faced with difficulties. Coping strategies include active problem-solving approaches, turning to friends and families for support, diversion by watching television or movies, fantasizing, numbing anxious and depressed feelings with drugs, alcohol, or even prayer.

At Columbia University researchers studied the interpersonal problem-solving skills of a group of adolescent girls who attempted suicide. The researchers concluded that “The most important finding of this study is that suicide attempters had poor interpersonal problem-solving skills to both psychiatrically disturbed non attempters and non disturbed non attempters. Suicide attempters’ generated fewer alternatives to solve stressful problems than
any other group and the difference was large enough to be potentially useful in discriminating suicide attempters from the other groups” (Rotheran-Borus, Piacentini, Miller, Graae, & Castro-Blanco, 1994).

IV. Normative: “What ought to be happening?”

Now I would like to turn our attention to discuss the prevention programs that are available in trying to control the epidemic of adolescent suicide. The Center for Disease Control has published a very useful book entitled “Youth Suicide Prevention Programs: A Resource Guide (1992)”. The book describes the different types of programs that are operating in the United States that have been developed to prevent suicides from happening. In the book the programs are divided into eight different categories. These are: 1) school gatekeeper, 2) community gatekeeper, 3) general suicide education, 4) screening, 5) peer support programs, 6) crisis centers and hotlines, 7) means restriction, and 8) intervention after suicide. I would like to examine some examples as outlined in the book “Youth Suicide Prevention Programs: A Resource Guide of ongoing programs in these different areas that is offered in the book to see what is being done in the United States to prevent suicide.

School Gatekeeping Training

The term refers to the need for adults to help adolescents obtain treatment when the adolescent is seriously considering suicide as a viable option. School counselors working in the school would be in one of the best positions to be a gatekeeper. There are potentially important roles here for anyone who has frequent contact with the students. To best utilize the school staff in suicide prevention efforts, it is important to sensitize the staff to the behaviors that make up a suicidal risk so that the staff members can initiate the process of bringing the child to the attention of the mental health professionals in the community. The devised training programs are to teach school personnel about suicidal behavior. These programs have been developed and tried out in a number of school systems.

In Dallas, Texas the school system has developed a project with the acronym of SOAR, which stands for, Suicide: Options, Awareness, Relief. The program consists of suicide
awareness lessons for teachers and staff, along with training for school counselors at the elementary and secondary levels. The training for counselors is more intensive, helping them to make risk assessments of students who are potentially suicidal. The typical counselor would receive six hours of training and some designated counselors would receive the extensive training in risk assessment. The instruction includes information about crisis theory, the dynamics of suicide, and how to identify students at risk. In the instructional sessions the trainers try to sharpen the listening skills of the counselor and improve their ability at being an empathetic listener.

Community Gatekeeping Training

The ideas behind these programs are very similar to those of the school gatekeeper training. The primary objective is to train people to identify young people at risk for suicidal behavior and refer them to professional help. The difference here is that the people trained work at diverse jobs in the community. They could be members of the clergy, police, nurses, or even probation officers. They are people with significant contact with youth in their everyday work.

An example of this can be taken from the community in Calgary, Canada. The core of the program is a two-day workshop that trains people to deal with the emergency situations dealing with a potential suicide. The participants observe people demonstrating appropriate responses to suicidal threats. Then the participants practice these behaviors themselves. These types of programs have been a huge success. More than 50,000 people from the Unites States, Canada, Europe, and Australia have taken part in the training. A similar program has been set up in the Sacramento, California region.

General Suicide Education

In general, educational programs about suicide are designed to provide in high schools as well as in middle and elementary schools. These programs vary at length. One of the programs on suicide prevention used eight one-hour classes whereas another offered four sessions lasting about 50 minutes each. Ideally, the programs should be long enough to discuss
important topics related to suicide, but not so long as to create a preoccupation with suicide. Some of the topics included in these programs are 1) the warning signs of suicide, 2) where to get help, 3) how to help a suicidal friend, 4) developing effective problem-solving strategies, 5) self-esteem, 6) coping with loss, 7) developing control, 8) listening skills, and 9) attitudes toward suicide.

One might ask how well do these programs work. Studies reported by the New Jersey Adolescent Suicide Project indicate students who participate in the programs have a better working knowledge of the signs of suicide than that of students who do not participate. An example of this is that 80% of the students who took the course could recognize being “sad or depressed” as being a warning sign of suicide. Compared to 68% of those who did not participate in the program could not recognize being “sad or depressed” as a warning sign of suicide. True that the difference is not huge, it is statistically significant. These findings indicate that prevention programs can teach substantive materials about suicide.

Screening Programs

The idea for suicide screening programs is based on earlier experiences with screening programs in public health. To apply this approach to suicide prevention you must have a quick and accurate way of determining whether a person is a suicide risk. The method researchers have concentrated on is the “paper and pen test”, a series of questions asking about suicidal thoughts, intent, and related behaviors. As a general rule of thumb the higher the test scores the greater the risk of suicide. The goal for a screening test is to correctly identify as many of the people who have the problem as possible while keeping mistakes of classifying people to an acceptable level.

In the absence of well tested, accurate screening instruments to identify suicide risks some schools have tried to develop screening systems of their own. The schools in Dade County, Florida, maintain what they call a student intervention profile. Every nine weeks the profile that contains seven elements (grades, attendance, homework issues, behavior issues, detentions, suspensions, and truancy) is updated. If there is a change in the profile in three or more areas, a school counselor will contact the student for a conference that could include
parents. A drop in the number of suicides has been recorded among the student population, but whether the school screening program played any role in this change is not clear.

**Peer Support Groups**

If one can identify young people who seem at risk, it may be able to head off serious problems with preventative measures. A creative way of doing this is to involve other young people in the process. Allow teens to help teens. Peer support groups are a tremendous idea. Teenagers seek each other out when they deal with personal problems of their own. If a young person has few or no friends, why not help to create some. The role of the adult in this process is to identify young people with problems, recruit other stable young people interested in helping, secure a safe place to meet, and provide guidance when needed.

An example of this is established in Bothell, Washington. The program was set up by the Youth Suicide Prevention Center and continued to meet under private auspices enabling peer groups to meet once a week. The groups included some young people who thought about suicide, some that attempted suicide, and others who were concerned about some of their friends committing suicide. During the meetings there discussions included a wide variety of topics that included: problems with parents, dating relationship issues, drug and alcohol use, problems relating to school, and difficult life changes.

The hope is that in such groups high risk youth will develop supportive friendships and learn better ways of coping with interpersonal problems. Programs like these have been used previously in attempts to prevent drug use.

**Hotlines**

The word hotline has the impression of the “dramatic” or “urgency”. Something needs to be done and it needs to be done now. Hotlines for ventilation of urgent psychological problems serve an important, sometimes critical, function. There are now several hundred hotlines and crisis centers across the United States. In the event that a community does not have a suicide hotline, a troubled adolescent girl might call the “Chicago-based National
Runaway Switchboard, which often take calls from suicidal adolescents and will refer the caller to resources in their local area.

Staffed mainly by volunteers trained to respond to suicidal calls, many hotlines operate on a 24-hour basis. The staff provides crisis counseling to deter suicidal acts, offer emotional support to the caller, and may give out referral numbers for further help. Hotlines across the nation are similar in many respects though they may have their own procedures. In a Virginia community hotline volunteers received ten sessions of training that included some role playing. The emphasis was on training the volunteers to be empathetic listeners. The volunteer task was to reflect the caller’s feelings back to the caller, to help them discuss their feelings openly, and to help the caller discover their own solutions. The approach is similar to what the late Carl Rogers formulated in such books as “The Client-Centered Therapy”.

In general, when an adolescent calls the hotline, the volunteer is asked to make an assessment of the case through careful listening. The volunteer will place the case into one of three levels of criticality: suicidal thinking, suicidal planning, and imminent danger. In the event of a third level crisis situation, one strategy the volunteer may use is to try to work out an agreement with the caller or develop a contractual understanding. The volunteer will try to persuade the caller to call their therapist if there is one, call an emergency room, or call the hotline back before taking any actions that would be self-destructive.

As to the effectiveness of hotlines you are forced to conclude that the effectiveness is inconclusive. The evidence is still lacking to state that hotlines have a substantive impact on suicide rates in a community. When it comes to helping individuals in trouble, who would not want this service available?

Means Restriction

By means restriction, we mean reducing access to ways of committing suicide. This is an important concept in the prevention of suicide in adolescents. Remember that for many young people suicide is an impulsive act. Impulses may be strong at any given moment, but with the
passing of time they may dissipate. If the means toward the harm is not available there is a less chance of the suicide taking place.

When you ask yourself how young people succeed in taking their own lives, the answer is clear enough. Guns are the principal means. Nearly two thirds of young men between the ages of 15-24 who kill themselves use a gun. The figures for young women are 45%, or just under half. It is very easy to make the argument that if you restrict the access to firearms of young people with suicidal thinking, you will save lives.

There are statistics to support the argument. In the Seattle area of Washington, where access to handguns is considerably easier than in is across the border in Vancouver, Canada, the suicide rate for young people is ten times higher. For other means of suicide (poisoning, hanging, drowning) the rates are about the same. The combination of a suicidal impulse and the ready availability of a gun can be lethal.

**Intervention After Suicide**

The final type of prevention program described in the CDC’s book on suicide prevention is an attempt to lessen the chances of suicide clusters. The CDC suggests that a community should have a plan of action ready to implement in the event of an adolescent suicide to decrease the probability of suicide clusters. The CDC recommends that the plan should include the following elements:

- The community should establish a coordinating committee, knowledgeable and ready to act
- In the event of an adolescent suicide, the coordinating committee should contact key people, such as counselors and teachers in the school. These key people would be debriefed on the way to announce the death, on the need to support classmates of the deceased, and on the need to identify and counsel close friends of the deceased and other high risk students.
- In dealing with the suicide, the CDC stresses the importance of not sensationalizing the incident. The student’s action should not be glorified.
The committee should provide accurate information to the media.

An effort should be made to look for elements in the environment that might contribute to additional suicides and change them.

Considerations should be given to long range issues suggested by the suicide and to possible modifications in the community’s suicide prevention programs.

V. Pragmatic: How might we respond?

As a follower of Jesus I believe it is extremely important to have a proper Biblical perspective of suicide. I would like to lay out my own personal Biblical view of suicide. As we read Scripture there are many individuals who endured tremendous hardships and carried heavy burdens. Psalm 73:14 says “All day long I have been plagued; I have been punished every morning” and Job cried out “May the day of my birth perish; why did I not perish at birth, and die as I came from the womb?” (Job3:3&11). If anyone had a reason to commit suicide it would be Job.

Suicide is not a new idea as we see a number of suicides recorded in Scripture and these are only the ones recorded. There might be many more. In the Old Testament Samson killed himself and all the other Philistines at the Temple of Dagon (Judges 16:26-30). King Saul decided to fall on his own sword rather than permit himself to be taken prisoner by the Philistines (1 Samuel 31:4) and Saul’s armor-bearer did the same thing and died with Saul (1 Samuel 31:5). Abimilech in Judges 9:50-55 asked his armor-bearer to kill him so a woman would not. Ahithophel who was a counselor to King David put his house in order and then hanged himself (2 Samuel 17:23). King Zimri saw that his royal city had fallen into the hands of his enemies, went to his royal palace and set it on fire. He perished in the flames (1 Kings 16:18). The most famous of all suicides is that of Judas Iscariot. He was one of the Twelve; he betrayed Jesus with a kiss and then went out and hanged himself (Matthew 27:5).

In the above suicide cases in no way does the Bible support or endorse suicide. Rather what we see in Scripture time and time again is the sanctity of life and the moral conviction that life is the Lord’s. Life is the Lord’s to give and His to take away. In Hannah’s prayer in 1 Samuel
2:6 she prays “The Lord brings death and makes alive; he brings down to the grave and raises up.” In light of this I believe it is abundantly clear that suicide is certainly not the Lord’s way. A verse that I cling to over and over during my difficult days is found in John 16:33 “In this world you will have trouble. But take heart I have overcome the world”. God’s way is to have His children to turn to Him in times of hardships and find the hope, strength, and purpose He has for you rather than end one’s life in the despair of suicide.

As we respond to adolescent suicide from a biblical perspective we must answer the question is suicide the unforgivable sin? The Catholic Church tried to stop people from committing suicide by declaring it the unpardonable sin. During the medieval period a proper Christian burial was denied to those who committed suicide. It is not the specific act Jesus identified as the unforgivable sin in Matthew 12:31. Does a person who commits suicide end his or her life with a sin that because it is the final act of the person’s life cannot be confessed and forgiven? The best answer that I found to this question is from Baker and Nester in their book “Depression: Finding Hope and Meaning in Life’s Darkest Shadow”

“These feel that suicide is the ultimate sin for which there is no forgiveness. This is obviously a misunderstanding of the Gospel of God’s grace. The only sin that truly keep’s one from God’s presence is the sin of unbelief-of not trusting the work of Christ personally. The inability to confess suicide as a sin is not a real issue.

God’s forgiveness gives me a position as His child and deals with all of my sin-past, present, and future. If salvation depended upon confessing every sin committed as a believer, no one would qualify! We have all sinned in ways we either were not aware of or were not concerned about enough to confess individually.

Payment God does not twice demand

First at my bleeding Surety’s hand

And then again at mine.
The unfortunate and sad ending of an individual’s life by his own hand does not nullify the effect of the grace of God in his life. Suicide victims who are children of God are redeemed souls in the presence of their Heavenly Father.” (pg 180-181)

Now that we have a proper Biblical view of suicide as ministers of the grace of God how should we respond to the survivors of a suicide? How do we respond to the grief one suffers from? In life we learn how to acquire things not what to do when we lose them. As I child I knew how to act so I would receive birthday and Christmas presents. I learned if I wanted to receive praise from my parents I would try hard in school to earn good grades. I knew I needed to attend and graduate from college if I wanted to be successfully employed. Everything in life we learn what to do to acquire things, we are not taught what to do when we lose things. The problem is grief is messy. There is nothing neat or structured about it and we all grieve in different ways. As called ministers of the grace of God we have a responsibility to be effective ministers at times of tragedy. We should not run and hide from it.

Psychologist Gary R. Collins has this to say about grief:

“Most discussions of grief, however, concern losses which come when a loved one or other meaningful person has died. Death, of course, happens to everyone and the mourners are left to grieve. Such grieving is never easy. As Christians we take comfort in the resurrection, but this does not soften the emptiness and pain of being forced to let go of someone we love. When we experience loss by death grievers are faced with an absolute, unalterable, irreversible situation; there is nothing they can do, for, or about that relationship” (Collins, Christian Counseling 411-412).

Grief is an important, normal response to the loss of a loved one to suicide; but it can be extremely devastating to the survivors of suicide. As we minister to those who are grieving it is imperative to understand the different stages of grief. Authors Joan Sturkie and Siang-Yang Tan in their book “Advanced Peer Counseling in Youth Groups” summarize Elizabeth Kubler-Ross widely accepted five stages of grief the following way:
Stage 1 – Denial- The person may refuse to believe that the death has occurred. This stage may vary in length, with some people staying in it longer than others. It is a temporary stage, but it may surface again at any time.

Stage 2- Anger- The survivors may question why the death occurred. When the answer is not apparent, he or she may lash out in anger at the seeming unfairness of it all.

Stage 3- Bargaining- This is usually an attempt to postpone the imminent death or cut a deal that will lessen the pain of grief or the reality of the separation. The bargaining is usually done in secrecy with God.

Stage 4- Depression- When the person faces the reality of the death, depression often sets in.

Stage 5-Acceptance- When the person works through the feelings and conflicts that have arisen, he or she may now be ready to accept the fact of the death. (Sturkie & Tan pg 489).

A wonderful way a church can respond to the grief of the survivors of suicide is to begin a support group. This is a real and tangible way to help those begin to rebuild their lives and help them through the stages of grief. Cox and Arrington say “Being a member of a group does several things. It provides a safe place to discuss what you are thinking and feeling with other people who understand your unique pain. A support group also helps you to realize you are not the only one going through the complex emotional process of healing from suicide” (Aftershock, pg 89). As you read the book “Aftershock” you will hear the story of a man named Larry early on. Larry grew up in a small, mountainous, eastern Kentucky coal mining town. He describes his hometown as “good people but hurting people”. His father and most of his family were miners. In the culture of miners the education is low and depression is high with suicide being a major problem. The average suicide statistics for a county this size are 5 per 100,000. For Larry’s region they are 16 per 100,000. When Larry was 13 his brother closest to him in age attempted suicide. Right around this time his father contracted black lung disease and was forced to take disability. Also, during this time another brother attempted suicide by a drug overdose. Sometime later his sister attempted suicide while she was going through a divorce.
the late 1980s Larry’s father had been on disability for nearly twenty years and confined to the house on oxygen he attempted suicide twice by a drug overdose. Finally, on his third attempt he was successful. In discussion with one of his brothers following the death of the father, the brother stated he felt suicide was “their destiny”. Larry was determined not to have it be their family destiny and while living in Kentucky he formed his first suicide survivor’s group or better known as S.O.S. (survivors of suicide). He will tell you that S.O.S groups have played a major role in healing from the deaths in his family. He views that helping others through the tragedy of suicide is a way of bringing his family tragedies full circle.

In chapter 6 of Aftershock “Picking Up the Pieces: Deciding to Rebuild” Larry lays out a blueprint on how to begin an S.O.S. group in your area. His advice is as follows:

- Contact local pastors and/or mental health association.
- Solicit financial support. This usually involves only a small amount necessary for mailings, newsletters, and brochures. A church, funeral home, or mental health association may be willing to underwrite group expenses.
- Get the word out through local media - radio, television, and newspaper.
- Distribute brochures about the group to various locations, including mortuaries, cemeteries, hospitals, churches, and emergency medical personnel.
- Arrange to have a trained counselor facilitate the meetings.
- Use a free-form program “self help” format.
- It is fine to schedule speakers from time to time, but remember this limits the amount of time open for discussions.
- Once a group is organized consider publishing a quarterly newsletter.
- Provide each member with a group roster and have someone responsible for mailing monthly meeting notices.

VI Conclusion
COLIN CHADDETON

We will always remember this lonely young man
With his back to the wall and his heart in his hand
He is full of his courage and honor and pride
So he hides from the world what he's feeling inside
And he can't understand what his life is about
So he looks all around for another way out
And we think of him as a lonely young man

Is there really a place for this lonely young man?
Who gave up all the lies and traditional plans
He was good with his friends and his schoolwork as well
And your mind overflows with the things you could do
You would reach out and help him if only you knew
And we ache in our hearts for the lonely young man

Will he ever forgive us, this lonely young man?
All the people who love him, but don't understand
And we try not to hurt for the lonely young man
And we look on it now as a terrible loss
So we fall on our knees and humbly pray
And we're aching to speak but there's nothing to say
And we cry in the dark for the lonely young man

So the kingdom will mourn for this lonely young man
Who gave us his word and came down from the stand
And you know all at once that it won't be the same
And you're looking to fight but there's no one to blame
So you choke back your tears but your anger is blind
Cause he touches your life and he leaves you behind
And he chooses the path of a lonely young man

I am sure there's a place for this lonely young man
Who went all through his life with his head in the sand
When a laugh and a smile was all that you'd see
You would never suspect that he yearned to be free
So we bury our heads and we hang them in shame
And we cry in the night and we call out his name
And we try not to hurt for the lonely young man

What is happening now to the lonely young man?
Does he look down on us from a happier land?
Is he crying with us for the pain we have known?
Is he laughing at us from his heavenly throne?
And we'll try to forget but we just don't know how
Cause the memories are all we have left of him now
We will always remember this lonely young man

A FRIEND
I grew up in Bethpage, New York a small town on Long Island. There was a boy in my homeroom that I never took the time to get to know. We travelled in different circles. He was a straight A student in honors classes and I was not. He ran cross country and track, I was a swimmer. He was dating one girl for most of high school and I could not get a date. For Senior Superlatives he was voted “Fun and Friendly” and I was voted “Terribly Talkative”. His name was Colin Chadderton. During his senior year with his whole life ahead of him and college prospects he stopped coming to school in October of 82’ after cross country season was over. There were rumors around school but no one really knew his personal struggles. On a cold night in February of 83’, while his parents were out he made the fatal decision. He broke into his father’s gun case, took out a rifle, laid on his parents bed with the door locked and ended his life with one shot in the mouth. This act rocked our community, school, senior class, and homeroom. Our senior prom was not the same without him there with his girlfriend. He was remembered at graduation by an empty seat where he would have sat and a moment of silence.

Out of respect mostly everyone attended the funeral at St. Martin of Tours Catholic Church; including me. I do not remember what the priest said or any parts of the service. What I do remember are the tears of grief you heard from the family and the sense of sadness in the sanctuary like you have never experienced before. I recall wondering why Colin thought suicide was the only choice he had and the guilt I felt for never taking the time to get to know him. Maybe I could have been the concerned, compassionate external voice that tipped the scales to the side of choosing to live.

Our town, high school, and churches were not prepared to handle a tragedy of this magnitude. I always wondered could this have been prevented and what about the parents and the grief they must have endured. Is there any hope? Suicide brings suffering and difficulty into the lives of everyone who is touched by it. That was true of those who lived in Bethpage at the time and knew Colin Chadderton. In this suffering there is hope. God has come in the person of Jesus and has entered into the difficulties, the sufferings, the sins, and the disappointments of Jesus. Jesus has bore our weakness and was tempted as we are. The difference is that Jesus has
triumphed and He comes to us with the promises of mercy and goodness. Romans 8:32 says “He who did not spare his own Son, but gave him up for us all-how will he not also, along with him, graciously give us all things?”

Therefore, I conclude by stating there is hope in suicide. Through education, prevention, and support the Church of Jesus Christ can be a strong advocate in the suffering of adolescent suicide.
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See what patients have to say about Dr. Nancy Lanthorn, PHD, a highly rated Clinical Psychologist in Johnson City, TN. Biography. Dr. Nancy Lanthorn, PHD is a clinical psychologist in Johnson City, TN. She specializes in clinical psychology. Specialties. Clinical Psychology. Dr. Lanthorn's Reviews. Likelihood to recommend Dr. Lanthorn. 4.0. Terry Elton. Quite the same Wikipedia. Just better. What we do. Every page goes through several hundred of perfecting techniques; in live mode. Quite the same Wikipedia. Just better. He must also exclude himself from serving as an adviser in any form to the Public Health Services. Ohio State University also imposed its own penalties for Dr. Elton. These include not supervising any undergraduate or graduate students for three years, submitting all papers and grant applications to the university for review before proceeding with them for the next five years, and completing counseling on research misconduct and training on research ethics.