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Lived experience: Near-fatal adolescent suicide attempt

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Lived Experience: Near-Fatal Adolescent Suicide Attempt

by

Phyllis Ann Dougherty

A dissertation submitted in partial fulfillment
of the requirements for the degree of
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Dedication

This dissertation manuscript is dedicated with much love and affection to my loving parents, Phyllis A. and Daniel F. Dougherty, whose lifelong foundations of love, encouragement, support, and independence have inspired me and made all my dreams—and more—possible.

I owe many thanks to my wonderful sisters, Carolyn Dougherty Koonce and Denise Dougherty Kenyon, for their love and good listening skills.

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Table of Contents

List of Tables

List of Figures

Lived Experience: Near-Fatal Adolescent Suicide Attempt

Phyllis Ann Dougherty

ABSTRACT

Adolescent suicide has become a national health crisis. Suicide now ranks as a leading cause of adolescent death in the U.S. In response to this, the National Strategy for Suicide Prevention (2001b) recommended the promotion and support of research into suicide and prevention, particularly high-risk groups such as adolescents. However, due to concerns for safety and liability, there have been few studies of highly suicidal individuals, specifically adolescents. Leading suicidologists have agreed that studying the qualities of the near-fatal suicide attempt can most resemble the completed suicide.

This case study explored the phenomenon of the near-fatal suicide attempt through the lived experiences of seven adolescent females. Open-ended interviews that candidly expressed adolescent emotions and understanding of events surrounding the attempt were analyzed. Burnard's method of thematic content analysis of these provocative interviews revealed a collective adolescent voice.

Interviews were conducted on a locked in-patient psychiatric unit for adolescents. During the one-year enrollment, nine eligible adolescents were hospitalized after an attempted suicide with high intentionality and low rescuability, a level of lethality that is considered serious/near-lethal on the Risk-Rescue Suicide Assessment Scale. Two

individuals—both male—declined to participate.

A model was developed based on the content analysis of interviews with seven adolescent females in the case study. The model of a path of an adolescent near-fatal suicide attempt illustrated estrangement and eventual alienation from the adolescent's two major social support groups: parents and peers. A lack of a self-identity to cope with stressful experiences in a more rational manner contributed to the pathway. Parenting issues were highlighted by the adolescent's perception of non-supportive communication. Peer issues contributed to the subjects' perception of a lack of social support through their rejection and ridicule of the subjects. Coupled with the impulsivity of youth and mental illness, these subjects were not able to withstand the perception of extreme stress. Resultant near-fatal suicide attempts were initiated with significant ambivalence and no prior communication of intent. Alienation and a lack of appropriate coping skills placed these adolescents at high risk of a near-fatal suicide attempt.

Chapter I

Introduction

Extent of the Problem

Adolescent suicide has become a national health crisis. The adolescent suicide

rate has risen to alarming proportions trending upward since the 1950's. Within the past

six decades, dramatic increases in suicide rates have been the norm rather than the

exception (Cash & Bridges, 2009). Between 1950 and 1990, there was an historic

increase in the number of suicides for all adolescents ages 15 to 19 years (2.7 to

11.1/100,000) while adolescent male suicides in this age group rose to unprecedented

numbers ([3.5 to 18.1/100,000]; Centers for Disease Control [CDC], 1997, 2009c;

Craigshead & Nemeroff, 2004).

Black adolescents have experienced dramatic increases in suicide rates over the

past several decades. Notably, incidence rates increased for black males, 10 to 14 years,

climbing from 0.3/100,000 in 1979 to 1.7/100,000 in 2006 representing a 5-fold increase.

In stark contrast during the same period, suicides in white males in this age group rose

from 1.2 to 1.9/100,000, a 1.5-fold increase. For black males, 15 to 19 years, the rate was

6.7/100,000 in 1979 rising steadily to a high of 16.4/100,000 (2.4-fold increase) in 1994,

while concurrently, suicides for white males did not rise as significantly from

14.3/100,000 to 18.4/100,000 ([1.3-fold increase]; CDC, 2009c).

Suicide rates slowed through 2006 to 7.7/100,000 for all adolescent age groups.

However, for white males, 15 to 19 years, rates at 12.3/100,000 continue to remain a

1

significant public health concern. Among ages 15 to 19 years, black adolescent suicide

incidence rates increased from 6.7/100,000 in 1979 to 6.9/100,000 in 2006 with a

concurrent decrease for white adolescents from 14.3/100,000 to 12.3/100,000 suicides

(CDC, 2009c). Firearms have accounted for over 95% of the increase in black adolescent

suicides among ages 15 to 19 years ([males: 72% and both sexes: 69%]; CDC, 1998,

2009a).

Despite these trends, the adolescent suicide rate began a steady decline from 1994

through 2003. However, during 2003 to 2004, there was a dramatic increase in adolescent

suicides. This represented the largest single-year increase in 15 years as the rate soared

by 8 percent ([6.78 to 7.32 per 100,000]; Bridge, Greenhouse, & Weldon, 2008; CDC,

2007b).

During 2004, these significant upward departures were noted in total suicide rates

for three of the six age and gender groups. There was a tremendous increase in suicide

rates from 2003 to 2004 among female adolescents. In the 10 to 14 year age group, black

females had a 2.2-fold increase (0.5 to 1.1/100,000) and white females had a 1.8-fold

increase (0.5 to 0.9/100,000), both significant. In the 15 to 19 year age group, black

females again had a significant yearly increase of 2.1-fold ([0.9 to 1.9/100,000]; CDC,

2007b, 2009c). Adolescent mortality rates also continued to be higher than expected

though 2005 ([1.9/100,000, all adolescents, 10 to 14 years; 13.2/100,000, white males,

and 6.9/100,000, black males, 15-19 years]; Bridge et al., 2008; CDC, 2009c).

Mortality from suicide among American Indians and Alaska Natives (AI/AN)

under age 25 years has become the leading cause of death in these youth. Between 1999

and 2005, there was a significant jump in urban and rural AI/AN suicide rates among females, 15 to 19 years (6.9 to 14.9/100,000), more than doubling the rate. Unfortunately, many of these statistics are unreliable. Tracking by the Indian Health Service has indicated rural AI/AN populations have incidence rates ranging from 20.2 to 45.9/100,000 suicides. Within the AI/AN populations, rates have remained consistently above the national averages. Records in the past decade indicated rates from 30.9/100,000 in 1999 to 30.4/100,000 in 2006, the most recent data available (CDC, 2009a). However, concern about suicide rates among the White Mountain Apache youth under age 25 years, led to a tribally mandated surveillance that indicated the rate was 128.5/100,000 suicides ([2001 to 2006]; CDC, 2009a; Mullany et al., 2009).

Adolescence is a particularly vulnerable period in life. Not equipped with sufficient life skills, older adolescents engage in more high risk behaviors, desperately seek peer approval, and experience more conflict with authority figures (Erwin, 2002). Subsequently, it comes as little surprise that they also have a higher incidence of violent death, especially suicide. Suicide rates for all adolescents ages 15 to 19 years remained nearly six times as high as ages 10 to 14 years (CDC, 2009a). In a recent national survey (CDC, 2008), it was determined that nearly 14.5% of adolescents in grades 9 through 12 reported serious consideration of suicide while 6.9% of students actually attempted suicide during the previous year and 2.0% were treated for the resulting injuries. Nearly 30% of all students in grades 9 through 12 felt so sad or hopeless that they had stopped their usual activities for two or more weeks during the previous year (CDC, 2008). Historically, students in alternative high schools had reported notably higher rates of

these behaviors with 25% of those students reporting serious consideration of suicide and over 16% attempting suicide (CDC, 1999). Statistics have indicated for every completed adolescent suicide that 100 to 200 suicide attempts are made each year (CDC, 2007b).

These statistics and others have established suicide as the 3rd leading cause of death for youth ages 10 to 19 years, yet only the 11th leading cause of death in all age groups (CDC, 2009c). In dramatic comparison, between 1950 and 2005, the national (age-adjusted) death rates from the three leading causes of death have declined. The death rate from heart disease, the leading cause of death in the U.S., was 64% lower. The death rate from stroke, the 3rd leading cause of death, was 74% lower, and the death rate from cancer, the 2nd leading cause of death, was 15% lower during this same period (CDC, 2008).

Defining Suicide

In defining suicide, the succinct illustration would be as follows: Suicide (sōō ĭ sīd) n. [Latin sui, of oneself + CIDE, a killing].

1. An act or instance of intentionally killing oneself.

2. An individual who commits suicide (Maris, 2000).

There are many ways to characterize suicide. The person who habitually drives recklessly or is addicted to some harmful substance could be said by others to be suicidal, as could the soldier hero who remains behind to cover his comrades as they retreat knowing there is no way for him to survive. Socrates was sentenced to death by self-ingestion of a poison. Jonestown was called a massacre, yet the majority of those who died freely drank cyanide-laced juice while understanding fully the consequences. There

are those who commit "suicide by cop" yet these individuals did not pull a trigger, but obligated law enforcement officers to shoot them. Are these suicides? Modern society has several definitions of suicide. The word *suicide* probably first appeared in literature in the mid-1600s and has expanded in scope in the ensuing centuries.

Legally, suicide is defined by the medical examiner as a voluntary action resulting in one's own death. The manual for International Classification of Diseases (ICD-9) codes and classifies mortality data for death certificates (Codes E950-E959 reference standards for coding suicide and self-inflicted injury). The ICD-9 codes are the legal standards to declare suicide as a cause of death (World Health Organization [WHO], 2008). The ICD-9 codes specify the intent in the action of suicide is fatal in a manner that is willful, self-inflicted, and life-threatening, and without the desire to live. Suicidal intent, motive, and means must be a preponderance of the evidence in the legal determination of death by suicide (Johnson, 2000).

The existential definition of suicide is a conscious act of self-annihilation. Menninger's (1938) dark, psychoanalytic view of suicide was of self-hatred and self-loathing. He viewed it simply as self-murder involving hatred, the wish to die, guilt, and hopelessness. A philosophical approach delineates suicide into four elements. The element of fatality, in that a death occurs; the element of reflexivity which is by one's own doing; an element of action or inaction, that is, active or passive means of bringing about the act; and the element of intentionality presuming that ending one's own life must be the desired outcome (Mayo, 1992).

Durkheim's (1897/1951) sociological vantage point defined suicide as non-psychological or psychiatric in nature. It was a death resulting from a direct or indirect, positive or negative act of the victim understood to cause death. This unbiased definition was a scientific approach that took suicide out of the category of insanity, the prevalent judgment in the 19th century. Alternatively, Durkheim saw suicide as a symptom of disengagement from a society that ultimately, and fatally, failed the individual (Berrios & Mohanna, 2001).

Currently, suicidologists define suicide as a multi-faceted condition containing components of the "biologic, cultural, sociological, interpersonal, intrapsychic, logical, conscious, unconscious, and philosophical" [and to] "respond to or redress certain psychological needs" (Leenaars, 1999, p. 154). Shneidman (1985) simply defined suicide as a conscious act of self-destruction resulting from "a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution" (p. 203).

Purpose of the Study

The purpose of this qualitative study was to record the personal experiences, thoughts, and feelings of the adolescent's lived experience of a near-fatal suicide attempt. The goal was to express how this lived experience was created and given meaning. It allowed the adolescent to speak anonymously to personal reasoning and emotion to end their lives. This study proposed that the adolescents themselves define the factors important to their attempts. These individual expressions of the experience were categorized. Deconstruction of the emotions in such a decision ultimately and cogently

reflected patterns or themes in the collective adolescent reasoning to commit suicide (Vidich & Lyman, 1998). Giving voice to the diversity of intense emotions behind such a disquieting attempt to end a life prevents marginalization of the subject and provides insight into the mind of the adolescent.

Survivors of near-lethal attempts are theorized to be most like suicide completers based on recent research (Cutcliffe & Ball, 2009; Hawton, 2001; Simon, Swann, Powell, Potter, Kresnow, & O'Carroll, 2001; WHO, 2002). With these individuals, the investigator directly communicates and obtains information related to the cognitive processes, mental health and biological factors, and pertenient risk factors involved in the attempt (Hawton, 2001). The purpose in selecting the critical high risk—low rescue attempt was to focus on adolescents who did not expect to survive their attempt. While not actually ending in suicide, the psychological and emotional factors involved in a near-fatal attempt are most likely to resemble a completed suicide for the purposes of research. Suicidologists concur that the individual's suicidal intent is likely the most important indicator of potential lethality. While it is easy to understand the potential lethality of a gunshot, the overdose (OD) is frequently seen as a meager attempt at suicide. However, when one notes that many victims truly believe that they will die from an OD, this too indicated serious intent (Hawton, 2001; Simon et al., 2001). In studying this parallel attempt at suicide, the surviving individuals themselves can express the multi-layered psychological forces propelling them toward the act. These facts are not generally available to investigators in completed suicides. These are the unanswered questions, left for bereaved family and friends who sometimes cannot begin to fathom the suicide.

7

Importance of the Study

Having reached unprecedented proportions, suicide is now a leading cause of death in the at-risk population of ages 10 to 19 years. In 1981, suicide was the 6th leading cause of death in all youth age 10 to 14 years. It is now the 4th leading cause of death in this age group. In 1981, suicide in black males age 10 to 14 years was ranked as the 10th leading cause of death, but has now climbed to the 4th leading cause of death.Between 1981 and 2006, suicide remained the 2nd leading cause of death in while males age 15 to 19 years (CDC, 2010). Adolescent suicide has become a major public health issue requiring thorough analysis to differentiate multiple complex components for prevention efforts. With the rates of adolescent suicide projected to escalate dramatically, research has yet to find specific precursors for intervention purposes.

Quantitative research has dominated these efforts to predict and prevent adolescent suicide. The majority of published analyses are of the uncompleted suicide, but it is more apparent after much study that these non-completers are not emblematic of those who eventually succeed. However, the study of the completed suicide has become a mainstay in the body of research for evaluating variables to predict suicide. This field of inquiry has almost exclusively centered on statistical analysis of variables from a suicide victim's psychological autopsy. The psychological variables in this method were generally obtained through pre-determined questions to grieving, and often guilt-ridden, families and others closest to the victim (Hawton, 2001).

Basing the study of suicide on an evaluation of the suicide victim depends on the post-mortem process of the reconstruction of a completed suicide victim's life. It is contingent upon

8

biographic, social, and environmental information, medical and/or psychiatric files including the medical examiner's autopsy, and interviews with survivors (family, teachers, friends, and peers). The goal of this type of evaluation is to attempt to understand precipitating factors in the suicide. It relies on historical, and probably biased, data from grief-stricken parents and family, and on friends, teachers, and other persons close to the victim. This approach does not obtain access to certain issues, such as personal problems (Hawton et al., 1998; Lee et al., 1999; Reed & Greenwald, 1991; Seguin, Lesage, & Kiely, 1994; Tulloch, Blizzard, & Pinkus, 1997; Velting et al., 1998).

The majority of suicide studies are the result of a quantitative design utilizing the psychological autopsy. There have been no significant qualitative studies in either medicine or nursing. In a review of the literature, major publications of adolescent suicide in the U.S. prior to the year 2000 were limited to quantitative studies representing approximately 903 suicides with nearly 70% of the suicides occurring prior to 1989 (Dougherty, 2007). No quantitative study of adolescent suicide has definitively established the psychological profile of an adolescent at high risk for a completed suicide (Fortune & Hawton, 2007; Hawton, 2001). Studies have demonstrated that reasons for attempts given by individuals differ from the reasons ascribed by their psychiatrist (Hawton et al., 1998). Frequently, parents are unaware of the emotional turmoil suffered by the adolescent. After a suicide, parents often express disbelief at the act (Lee et al., 1999; Parker & McNally, 2008). While a valuable tool, this type of evaluation of suicide victims done after the fact has been entitled *assessment in absentia* (Clark & Horton-Deutsch, 1992, p.144). This quantitative research thrust of the past six decades has

9

minimally impacted the escalating adolescent suicide rates (Fortune & Hawton, 2007; Hawton, 2001).

Recent critiques of suicidology research stressed differences in precursors of the completed suicide, near-fatal suicide attempt, and non-lethal suicide attempt (Conner, Duberstein, Conwell, Seidlitz, & Caine, 2001; Fortune & Hawton, 2007). The discipline of suicidology is now beginning to question the predominance of studies of suicidal ideation, suicidal gestures, and non-lethal suicide attempts "as the correlation between intent and outcome is problematic" (World Health Organization [WHO], 2002, p. 185).

Therefore, as the illness process and response in a near-fatal suicide attempt most closely resembles a completed suicide, suicidologists have begun an exploratory shift to focus on the near-fatal attempt. Through the unique approach of the qualitative method, this study found relevance for suicide prevention efforts among adolescents through a focus on the emotions and experiences of the suvivors of these near-fatal attempts. Questions to survivors in the psychological autopsy were devised by the investigators. Consequently, by allowing the adolescent to define the lived experience of a near-fatal suicide attempt, new avenues of research may be opened.

Sharing the lived experience of a near-fatal attempt may provide insight into individual precipitating factors. This validation can lead to insight and thus healing can begin. Self-esteem may be enhanced by seeking to prevent other teens from suicide through their participation in the research.

Qualitative study invites interpretation and understanding rather than the observation and explanation encountered in traditional quantitative research (Edie, 1984).

It hears the inner voices of these adolescents. It gives expression to the personal reality of an individual's choice to attempt suicide. It is the investigator's responsibility to appreciate the natural evolution of the adolescents' self-destructive impulses. These can only be defined by the victim. Unraveling and deconstructing the basic tenets depends on allowing the adolescent to fully speak to emotions involved in the decision to attempt such a final act. To build a foundation of salient research, the narration of the suicide event must be expressed by the individual adolescent.

Specific Aims

Aim 1. Promote nursing science theory in the practice of prediction and prevention of adolescent suicide through the qualitative investigation of the lived experience of adolescent near-fatal suicide attempts.

Aim 2. Provide alternative research data through the qualitative study of near-fatal suicide attempts to contribute to adolescent suicide prediction and prevention efforts.

Aim 3. Provide data to examine the emerging patterns in the adolescent near-fatal suicide attempt based on qualitative data coding obtained through the lived experiences of those adolescents.

Aim 4. Express the inherent value of the perceptions, thoughts, and feelings of adolescent near-fatal suicide attempters by focusing on the qualitatively-obtained descriptive experience.

Adolescence

Struggling against perceptions of high degrees of social integration and regulation are hallmarks of the adolescent developmental stage. Adolescence is the transition

between childhood and adulthood in human development during which significant changes in cognitive abilities and sexual development occur. It is during this period that crucial identity, role, and independence evolve (Erikson, 1959, 1968).

Adolescence is a period of turmoil and negativism in which the individual begins to assert viewpoints in opposition to parental viewpoints, identifies with the omniscient peer group, and prepares for the tasks of adulthood (Sadock, Kaplan, & Sadock, 2007). Intense individuation and desire for decreasing parental authority (Piaget, 1952; Sullivan, 1953/1997) characterize this period.

During adolescence, the biological and psychological changes that take place can initiate developmental stress causing vulnerability. The need for separation and individuation erodes support from usual sources such as parents, family, and school, leaving the adolescent isolated and assailable (Aro, Marttunen, & Lonnqvist, 1993). Communication of needs and emotions can suffer or collapse totally (Shemanski-Aldrich & Cerel, 2009). Resultant depressed mood and feelings of hopelessness correspond closely with the intention of suicide (Beck, Rush, Shaw, & Emery, 1979).

Chapter II

Review of Literature

Suicidology

Durkheim, in his preeminent treatise *Le Suicide* (1897/1951), first hypothesized

that suicide was not random and facts existed that correlated the act of suicide with

specific sociological variables. Emile Durkheim (1858 to 1917), the renowned French

sociologist, published the prototype of systematic quantitative research on suicide in his

classic *Le Suicide* (1897/1951). As the founder of modern sociology, he first applied the

scientific method in discovering social facts. His was the first organized social

investigation of suicide, widely considered the most outstanding study of social causation

that analyzed the connection of suicide to social and natural phenomena (Pickering,

2001). Durkheim conceptualized suicide as the manifestation of the breakdown of social

bonds and moral community (Emirbayer, 2003) and as a failure of society, not the

psychology of the individual. Durkheim regarded suicide as symptom of "mental

alienation" (Berrios & Mohanna, 2001, p. 123), not insanity, which was an accepted

position through the preceding centuries. Durkheim is widely considered the founder of

suicidology. Durkheim's conceptualization of suicide as the choice between integration

and disintegration is the paradigm of modern suicidology (van Hooff, 2000). Since

publication of *Le Suicide*, suicidology has advanced the scientific study of suicide and its

complex, multi-dimensional variables and has engaged an entire community of investigators, educators, and others seeking to understand this poignant phenomenon.

Suicidology is the science of the study of suicide and suicide prevention. It is the behavioral science of a continuum of suicidal behaviors. It encompasses not only completed suicide, but also attempted suicide, self-destructive behaviors, and suicidal gestures. The continuum expands to include the non-lethal and the serious near-fatal attempted suicides; self-destructive behaviors and attitudes; self-mutilation and other suicidal gestures; ideations, threats, and communications; and the psychodynamics, motivation, and intent of suicide (Maris, 2000). "Because suicide is not one thing but many related overlapping phenomena, it follows that neither does it have one cause or etiology" (Maris et al., 2000, p. 4). Risk factors for the completed suicide encompass many facets of the adolescent experience such as psychosocial dynamics, substance abuse issues, family history and challenges, psychiatric issues, and societal expectations (Dougherty, 2007; Durkheim, 1897/1951; Kaminski & Fang, 2009; Maris et al., 2000; Shneidman, 2004).

Implicit in this self-destructive act is the intent to die, the importance of which is the person's perception of its likelihood to result in death by effecting suicide by a particular method (Maris, Berman, & Silverman, 2000). Lethality is derived from the Latin word *lethum* meaning death. Lethality is the medical certainty of death (Weishaar & Beck, 1992). Suicide by firearm is considered the most lethal method; although not always ending in death, it is generally not without serious life-altering consequences. It is doubtless survivors would have chosen such outcomes for themselves. Suffocation by

14

hanging is also among the more lethal methods (Shenassa, Catlin, & Buka, 2003),

although it is slow and apparently painful with much time to regret the action.

Lacerations range from serious disfigurement, requiring multiple surgeries if not fatal, to

barely visible scratches. Overdoses are considered to be among the least lethal yet many

succumb (Shenassa, Catlin, & Buka, 2003). Many victims do not understand the potential

lethality of such benign medications as acetaminophen that in toxic doses can lead to fatal

liver failure requiring transplant if available (Harris & Myers, 1997).

Suicidal Behaviors

The configurations of self-destructive behaviors are diverse. They have been

divided into categories of completed suicides, non-fatal suicide attempts, and suicidal

ideations (Maris, Berman, & Silverman, 2000). The suicide attempt is a non-fatal, self-

inflicted destructive action coupled with the intent to die. The importance of an attempt,

that by definition is a failed suicide, is the person's perception of its likelihood to result in

death. The near-fatal suicide attempt combines a significant degree of risk with little

probability of rescue. The manner of the attempt, evaluated for lethality and the potential

for rescue, is measured in terms of observable conditions and available resources present

at the attempt, not in treatment of the attempt (Weisman & Worden, 1972).

Suicidal ideation consists of the individual's thoughts of harming or killing

oneself. The frequency, intensity, duration, and intent of these thoughts are important in

determining seriousness. Suicidal communications are direct or indirect expressions of

suicidal ideations in any medium (verbally, written, drawing, art, etc.). The threat of

suicide is the communication of willingness, actual or deceptive, to commit suicide with

the intent to change the behaviors of others (Goldsmith, 2002). Not all threats of suicide are manipulative in a negative context. Frequently these expressions represent the extent of hopelessness and loss of self in the individual and depth of estrangement from all that they once identified with themselves. Hopelessness in an individual expressing suicidal ideation corresponds positively with intent to die (Beck, 1986).

Victimology

Victimology is the study of the endogenous and exogenous socio-bio-psychological characteristics/variables of a victim of suicide. It suggests these values recur in certain events in a cultural and societal context and are predictable. It seeks to illuminate the victim, an entity experiencing an imbalance in relation to itself and its environment. In an analysis of the individual victim, Shneidman (2004) remarked that each suicide or attempt contains unique meanings embedded in each aspect of the suicide. Each part of this experience has intense psychological importance for the victim, such as the method, the place, a note, a reason given or not given, or the perception of their final effect on survivors. However, the single most important factor for Shneidman was each suicide had the common thread for all individuals, which was "the best solution" (p. 202) to a perceived crisis. A victim is an entity experiencing an imbalance in relation to itself and its environment. The victim has perceived "disproportional costs for value received" (Rafai, 1982, p. 74). Ultimately, the study of suicide must be the study of the victim.

The study of suicide victimology in the U.S. effectively began with the classic St. Louis Study (Robins, Murphy, Wilkinson, Gassner & Kayes, 1959) of 134 successful suicides. Until this time, suicide studies were based principally on physician accounts,

suicides after psychiatric hospitalization, attempted suicides, and official statistical data (Robins et al., 1959). The study initiated the awareness that psychiatric illness, especially alcohol dependency, is one of the most influential predictors of the suicidal act (Allebeck & Allgulander, 1990; Brent, Perper, Moritz, Allman, Roth, Schweers, & Balash, 1993).

Psychiatric illness has been found to have a high correlation to suicide (Allebeck & Allgulander, 1990; Asgard, 1990; Cheng, 1995; Rich, Young, & Fowler, 1986; Rich, Fowler, Fogarty, & Young, 1988). Through the first systematic evaluation of consecutive suicides, Robins et al. (1959) provided the first distinct relationship of suicide to mental illness. Attempting to predict suicide through identifying variables, Robins et al. (1959) found that 94% of the study subjects were psychiatrically ill at the time of suicide. Specifically, a majority were diagnosed with alcohol dependency. Therefore, it was concluded suicide occurred almost exclusively in psychiatrically ill persons. These findings have been duplicated in subsequent studies at rates of 75%, 96%, 97%, 92%, and 84% (Allebeck & Allgulander, 1990; Asgard, 1990; Cheng, 1995; Rich, Young, & Fowler, 1986; Rich, Fowler, Fogarty, & Young, 1988). These early studies identified significant correlating factors such as substance abuse (24.8%) and comorbidity of substance abuse and affective disorders (39.84%).

Psychological Autopsy

The limitations of the pioneering study by Robins et al. (1959) are more apparent after nearly five decades. It is less scientific and systematic than current methods though it was a prominent and innovative study in 1959. Data in the St. Louis study were gathered using a ground-breaking method identified as the primary interview (Robins et

17

al., 1959), later labeled the *psychological autopsy* by the Los Angeles Suicide Prevention Center (LASPC). The LASPC further developed the psychological autopsy to resolve cause of death unequivocally in the urban medical examiner's cases of death of undetermined causes (Clark & Horton-Deutsch, 1992). Systematic inquiry was directed to past and present psychiatric and medical histories as well as to personal, family, and social histories and reviewed details and factors surrounding the suicide event.

The psychological autopsy is a unique post-death data collection strategy. This process of the reconstruction of a completed suicide is not limited to psychological factors. It examines biographic, social and environmental information, medical and/or psychiatric files including autopsy and interviews with survivors (family, teachers, friends, or peers) in an attempt to understand precipitating factors. While this method has no formal guidelines established (Isometsa, 2001), the reconstruction of a life after-the-fact can also incorporate any crucial personal data such as a victim's journal, diary, school essay, drawing, suicide note or other communication (recently video and website postings) regarding intent, reasons, or thoughts leading to the act.

The psychological autopsy was further refined for research purposes in a small study of adolescent suicides (Shafii, Carrigan, Whittinghill, and Derrick, 1985). The investigators began with contact at the funeral home and continued with a 3-year follow-up. This study developed and incorporated victim emotional disorder assessment and parental psychopathology assessment. Later studies of suicides further expanded the psychological autopsy seeking to gain an understanding of the principal diagnosis considered the most important factor in the suicide event. This information was balanced

with evidence and types of substance abuse, course of the psychiatric illness, and any treatment received by victims (Fowler et al., 1986). Psychiatrically trained interviewers related clinical and autopsy information to 300 standardized data items on each case prior to assigning diagnoses.

Early limitations of the psychological autopsy included a lack of inter-rater reliability testing. Few investigators were blinded to statistics (that is to say, toxicology reports) until after diagnostic determination to increase validity and reliability and decrease bias (Fowler et al., 1986). The validity of the psychological autopsy is now well supported for post-mortem psychiatric diagnostics (Brent et al., 1993; Durberstein, Conwell, & Caine, 1993). Studies of adolescent suicides have become increasingly systematic, complex, and scientific as suicidologists find an ever-intensifying crisis in the rare phenomenon of suicide. The groundbreaking investigation of Robins et al. (1959) educated a generation of scientists in basic reasons behind this act of self-destruction. Psychiatric disorder and substance abuse were seen objectively as key factors for those who saw suicide as a coping mechanism (Brent et al., 1987; Pages et al., 1997).

Substance Abuse

Subsequently, with the benefit of the psychological autopsy, alcohol use and intoxication have been identified as highly significant correlates of suicide (CDC, 2008; Dukarm, Byrd, Auinger, & Weitzman, 1996; Esposito-Smythers & Spirito, 2004; Giner et al., 2007; Moscicki, 1995). Not surprisingly, information processing is impeded in all aspects under the influence of alcohol and other substances (US Department of Health and Human Services [USDHHS], 1999). A significantly increased relationship between

suicidality and recent heavy alcohol use has been reported in adult alcoholic inpatients (Cornelius, Salloum, Say, Thase, & Mann, 1996) with over 82% reporting intoxication at the time of their suicide attempt. While the suicide attempter may not purposefully use alcohol to facilitate the act (Lester, 1992), many have reported their judgment was impaired by alcohol (47%) and their suicidal behavior was impulsive (e.g., less than 3 hours pre-meditation), and yet the vast majority (70%) thought it likely to result in death (Cornelius et al., 1996).

Current substance abuse has now been shown to be a highly significant predictor of suicidal intent (Marttunen, Henriksson, Aro, Heikkinen, Isometsa, & Lonnqvist, 1995). Impairment in judgment for the adolescent begins at blood alcohol concentrations of 0.02%, substantially lower than the legal limit for adults in most states (CDC, 2007a; National Safety Council, 2000). The impairment of judgment that accompanies this alcohol use increases the probability of suicide (Brent, Perper, & Allman, 1987). An analysis of the most recent data available (2005 to 2006) for 10 to 19 year old suicide victims found that 12% were associated with a $BAC \geq 0.08$, the legal limit (CDC, 2009a). Among racial/ethnic groups, blacks had the least numbers (5%) confirmed in other studies ([17.8 percent]; Garlow, Purselle, & Heninger, 2007). Alcohol has become the most abused substance by the nation's youth (CDC, 2007a). Alcohol use and intoxication has intensified among high school students (grades 9 to 12). Nationwide, over 44% of high school students reported current alcohol use (at least one drink on 1 day in the preceding 30 days). While about 36% of 9th graders reported current alcohol use, this figure steadily increased to nearly 55% of 12th graders. Nationwide, over 26% of high

school students reported binge drinking (e.g., five or more drinks within a couple of hours) on one or more occasions within the previous 30 days. Significantly more 12th grade males (40%) reported binge drinking (CDC, 2009a). More than twice as many alternative high school students (65%) reported such binge drinking in previous years (CDC, 1999).

The frequent use of alcohol and other drugs is a significant factor between completed and attempted suicide, 70% versus 29% respectively (Shafii, Carrigan, Whittinghill, & Derrick, 1985; Sher, Sperling, Zalsman, Vardi, & Merrick, 2006; Sher & Zalsman, 2005). Mood-altering substances are of particular note in a majority of recent suicide studies (Dougherty, 2007). Among suicide completers with a substance abuse disorder (alone or comorbid) versus those with other psychiatric diagnoses, a significantly higher number have positive toxicology screens ranged from 100% to 25 percent (Fowler et al., 1986; Garlow, Purselle, & Heninger, 2007; Singh & Lathrop, 2008). Nearly half of individuals who demonstrated evidence of abuse began abusing substances before age 18 years. There has been a dramatic rise in positive blood alcohol concentration (BAC) in suicide autopsies. In one period from 1968 to 1983, studies demonstrated that BACs rose 3.9-fold from 12% to 46% among completed suicide victims. These rates have not diminished throughout the intervening years (Giner et al., 2007; Singh & Lathrop, 2008). Comparably, from 1968 to 1983, there were no significant increases in the proportion of completed suicide victims who were under the influence of other drugs; the increases ranged from 9.5% to 16.1% in one study (Brent, Perper, and Allman, 1987). The National Violent Death Reporting System (NVDRS), a state-based

surveillance system, evaluated data from 2005 to 2006 (the most recent data available) for adolescent completed suicide victims in all racial/ethnic groups. In evaluating alcohol use, the NVDRS concluded that 12% of the adolescent suicides had BACs greater than or equal to 0.08 g/dl, which is the legal limit in all states; however, rates varied significantly between 1.3% and 28.6% across the various racial/ethnic populations. Among those adolescents intoxicated at the time of suicide, significantly more males (25%) than females (18%) had BACs greater than or equal to 0.08 g/dl (CDC, 2009a).

Firearms

Firearms have become the most common means of suicide in the U.S. (CDC, 2009a; Strieb et al., 2007). Rates for all firearm suicides (8 to 80 years, all races, both sexes) remained essentially unchanged from 1981 through 2006 (47.8% and 48.1%, respectively). Firearm suicides had a lethal outcome in nearly 90% of the cases (American Academy of Pediatrics, 2000; Annest et al., 1995). Persons who purchase a handgun are 57 times more likely to commit suicide within the following week and continue to have a significantly higher rate of suicide during the following six years (Sherman et al., 2001). The rates for firearm suicides in black males, 15 to 19 years remained relatively steady from 1981 to 2006 (58% and 60.2%, respectively). However, there was a 30.14% increase in the number of suicides. Brent, Perper, and Allman (1987) first demonstrated a significant increase in the use of firearms as the most common suicide method (a nearly 2-fold increase from 1.4 to 2.58). However, other methods such as hanging and poisoning increased only minimally from 1.25-fold to 2.08-fold. In 2006, firearms remained the most prevalent method of suicide for males, 15 to 19 years within

22

racial/ethnic groups (whites, 50.6%; blacks, 60.2%; Per 100,000: American

Indian/Alaska Native [AI/AN]; 13.6; Asian/Pacific Islander[A/PI]: 2.1; blacks, 4.2;

whites, 6.3 per 100,000 population). The increase in the choice of firearms in all violent

adolescent suicide in this age group has been corroborated in epidemiological studies

([45.1%]; CDC, 2008, 2009a; Vajani, Joseph, Crosby, Alexander, & Millet, 2007;

Wexler, Hill, Bertone-Johnson, & Fenaughty, 2008).

The disquieting trend in this suicide method stimulated questions about the

presence of guns in the home. Significant connections exist between firearms and their

accessibility in the home and the completion of the suicidal act (Brent et al., 1988;

Bukstein et al., 1993; McNamara & Findling, 2008; Streib et al., 2007). A gun in the

home increased the risk of adolescent firearm suicide by 70% per cent (Brent, 1988).

Correspondingly, states with higher gun ownership had 3.8-fold higher rates of overall

suicides (Miller & Hemenway, 2008; Miller, Lippman, & Azrael, 2007). Significantly,

firearms were likely to be present in the homes (74.1%) of adolescents completing

suicides than those attempting suicide (Brent et al., 1988). Most guns in the home are

stored unlocked and many are loaded, notwithstanding many state gun laws prohibiting

unsecured guns (Brent, 2001; McNamara & Findling, 2008). However, gun storage,

locked or unloaded, had no effect on the outcome of suicide (Brent et al., 1991; Wellford,

Pepper, & Retrie, 2005). Notably, a recent study showed that a majority (greater than

75%) of parents of depressed adolescents ignored warnings to remove guns from the

home and 17% acquired guns despite having been warned (Brent, Baugher, Birmaher,

Kolko, & Bridge, 2000; Sher, Sperling, Zalsman, Vardi, & Merrick, 2006). Data implied

that guns in the home have been predictive of suicide (Brent, 2001). The lethality of this method of suicide may be the key factor in the suicides of impulsive youth ages 16 years and younger with low-intent for suicide (Brent, 1987). In the U.S., the firearm suicide rate of adolescents of ages 5 to 14 years has been estimated to be 10 times higher than in other industrialized nations (Miller, Azrael, & Hemenway, 2002; Liu, 2009).

There is a highly significant association between firearms as a suicide method and BAC at time of death (Brent, Perper, & Allman, 1987; Dougherty, 2007). Binge drinking has been shown to be a significant factor in the suicide attempt among all youth, 10 to 19 years (Aseltine, Schilling, James, Glanovsky, & Jacobs, 2009; Windle, 2004). Coincidentally, binge drinking is on the rise among U.S. students. In a national risk survey (CDC, 2009a), nearly 25% of adolescents in grades 9 through 12 were engaged in binge drinking at any one time. Adolescent suicide victims who were acutely intoxicated (BAC greater than or equal to 0.1%) were (7.4 times) more likely to commit suicide using this highly lethal and violent method than those victims with no detectable levels (95%). More than twice as many completed suicides were related to alcohol abuse disorders when compared to attempted suicides in adolescents ([83% vs.44%, respectively]; Brent, Perper, Kolko et al., 1988; Bukstein et al., 1993; Kotila & Lonnqvist, 1989; Marttunen et al., 1992). Though not statistically significant, those suicides among adolescents under the influence of drugs, not alcohol, were more likely to die of a drug overdose. The acute intoxication of those contemplating suicide might predispose them to impulsive suicidal ideation and attempts through impaired judgment and depressed mood. Studies of near-lethal suicide attempts show that many suicide

victims (24%) took less than five minutes from the decision to kill themselves to the actual attempt, while the vast majority (70%) took less than one hour (Miller & Hemenway, 2008).

Multiple factors must collide to influence suicide. Substance abuse alone does not necessarily lead to suicide. Substance abusers have many risk factors that predispose them to suicide. Substance abuse disorders in suicide completers are more likely to be associated with comorbid affective disorders. A majority (59%) of these victims, in 78% of the time, used an available firearm to commit suicide while under the influence of alcohol or drugs (83% for alcohol and 39% for drugs; Brent 1995; Brent, Perper, & Allman, 1987; Bukstein et al., 1993). Many suicide completers (57%) had legal problems and significant family psychopathology, including affective disorders (41%), major depression (37%) and substance abuse disorders (27%). Fifty -seven percent of substance-abusing suicide completers experienced more parental violence than those who were not substance abusers (Brent, Perper, Moritz, Baugher et al., 1993; Bukstein et al., 1993; Marttunen et al., 1994). When adolescents without a diagnosis of comorbid affective disorder commit suicide, it appears that more impulsive expressions of suicide and prior attempts were minimal (less than 15%), compared to more lethal methods (100% for firearms) when available. Adolescents without a diagnosis of comorbid affective disorder are 27 times more likely to have a loaded handgun in their homes (87.5% have loaded handguns). While all of these adolescents used a handgun to end their lives, none had a positive toxicology screen impairing their judgment. The availability of gun-related suicide methods can determine lethality in impulsive

adolescents without apparent psychopathology (Brent, Perper, Moritz, Baugher et al.,

1993).

Gender Differences

There are significant differences in gender in adolescent suicide, which are

obvious since the overwhelming majority of suicides in all age groups are males. In

2006, among adolescents, males committed suicide nearly four times as often as females

(CDC, 2009c). However, the female suicide victims, who tended to be more depressed,

chose a less lethal method—overdose—as a suicide method 3.25 more often than their

male counterparts. Male victims, on the other hand, chose firearms 5.4 times more often

than overdose. Since firearm injuries are fatal more than 90% of the time, this probably

contributes to the higher number of completed suicides in males (CDC, 2009c). Both

genders experience profound life stressors, yet were not statistically significant. Stress for

the female victim is reflected in more frequent psychiatric care (47%) including

hospitalization (42%), possibly due to more frequent (63%) suicide attempts by less

lethal methods than firearms. Females often survived firearm suicide attempts since they

often did not shoot themselves in the head as did a majority males. Males experience

similar rates of life stressors, but attempt suicide at half the rate (30%) compared to

females receiving only minimal intervention (8% had psychiatric care and 7% had

hospitalization; Marttunen et al., 1992). Acutely intoxicated adolescents are (7 times)

more likely to use violent methods of suicide that are also more lethal, such as firearms

and hanging (Brent et al., 1987; Kotila & Lonnqvist, 1989). Alcohol abuse rates in

adolescent suicides were nearly equal between genders (females, 21% and males,26%)

with both groups having had significantly high rates of suicide under the influence of alcohol ([females, 47% and males, 60%]; Cornelius et al., 1996; Marttunen et al., 1992, 1994, 1995; Renaud, Berlim, Marcelo, McGirr, Tousignant, & Turecki, 2008). Current alcohol use is also relatively equal between genders in high schools across the country. The differences in proportions using alcohol for 10th, 11th, and 12th graders are insignificant (41.4% of 10th grade males vs. 42.3% of 10th grade females; 51.5% of 11th grade males vs. 46.5% of 11th grade females, and 55.6% of 12th grade males vs. 54.2% of 12th grade females). Heavy episodic drinking is similar in both genders (27.8% of males and 24.1% of females) in high schools (CDC, 2008).

Minority Suicide

The imbalance in the number of suicides committed by black youth has been a growing concern. Modern society has amplified psychosocial stressors for black adolescents, eroding the link between the individual and society. Traditionally protective factors in black society, such as the family, the church, and the community, have eroded (Fitzpatrick, Piko, & Miller, 2008). has also played a destructive role in the plunge into suicidal behaviors. The resultant distress may have triggered an increase in actions such as (Willis, Coombs, Cockerham, & Frison, 2002). There were periods when the suicide rates rose significantly. Between 1979 and 1998, suicide incidence rates for white adolescent males age 10 to 14 years rose from 1.2/100,000 to 2.5/100,000 and age 15-19 years rose from 14.3/100,000 to 15.1/100,000 population. However, there were dramatic changes for black adolescent males age 10 to 14 years with increases from 0.3/100,000 to 1.7/100,000 and age 15 to 19 years from 6.7/100,000 to 10.5/100,000 population (CDC,

2010). Firearms accounted for 96% of the increase (CDC, 1998). Rates remained

elevated over the 27-year period 1979 through 2006 for black adolescent males age 10 to

14 years (1.7/100,000) while rates for whites in this age group (1.4/100,000) declined. In

black adolescent males age 15 to 19 years, rates increased from 6.7/100,000 to

7.0/100,000, yet again declined for while adolescent males (14.3/100,000 to

12.3/100,000) in this age group. Despite these disquieting figures, there have been no

major published studies of risk factors unique to the black adolescent suicide victims.

Minority youth suicide is neglected despite critical increases. Most research has

included minority suicides as a small percentage in individual studies that give little

statistical value to these rates. In reviewing the major psychological autopsy studies of

the last decade, only three delineated race/ethnicity (Gould et al., 1996, 1998; Shaffer et

al., 1996), despite rate increases as high as 14.9/100,000 for black adolescents (ages 15 to

19 years) in 2005 (CDC, 2010). The increase has been even more stunning in the past

decade. Statistics during this time showed that suicides of 10 to 14 year old males

climbed more than 7-fold with strangulation (86.7%) as the predominant method (CDC,

2009c).

Latino adolescent suicides, traditionally low, have been a part of the rising trend

in minority suicides. In 1991, the Latino adolescent suicide rate was 10/100,000;

however, by 1995, it had increased to 17.75/100,000 (Hayes-Bautista et al., 2002).

Unfortunately, the characteristics of Latino adolescent suicide have been neglected in

published research with one exception (Dougherty, 2007).

Queralt (1993), in a psychosocial analysis, found the proportion of Latino adolescent suicides to be dramatically higher than that of Latinos in the area's general population (61% for ages 13 to 19 years and 80% for ages 13 to 14 years) compared to older Latinos (46%). Ethnicity was disproportionately represented in these suicides compared to the area's general population. Cubans, 67% of the area populace, constituted only 15% of suicides while Puerto Rican youth, a mere 6% in the populace, represented nearly 40% of the suicides. While many were immigrants and all parents were from Latin America, acculturation issues were insignificant.

Ethnicity is a major limiting factor in nearly all U.S. studies of adolescent suicide. While the fact that white suicides outnumber all other racial/ethnic groups was well known, frequently no other ethnic groups were included for the analyses (Dougherty, 2007). Due to significant racial/cultural differences, these findings for white adolescents cannot be extrapolated to African-American, Hispanic, or other minority suicides.

The inclusion of women, children, and racial /ethnic minority groups and their sub-populations in research is a strategic objective toward the eventual development of interventions unique to these groups. There are obvious significant differences of public health importance in adolescent suicides to be calculated between these sub-groups. This policy should result in a variety of specific research outcomes to address the significant gaps in knowledge related to suicide deaths affecting these understudied groups.

Adolescents are an at-risk population in the midst of an epidemic of suicides. Keeping in mind the National Institute of Health (NIH) mandate to include children in research, this type of inquiry can provide a much needed scientific basis for reducing the

risk of adolescent suicide through prevention efforts that focus on fundamental issues identified by the adolescents themselves rather than by the investigator.

Summary

This review of literature represented an evolution of understanding the psychological power of the suicide event in adolescents. Studies have become increasingly systematic, complex, and scientific as suicidologists find an ever-intensifying crisis in the phenomenon of adolescent suicide. As an innovative method of reconstruction of a personality and all its components (Brent, Perper, Moritz, Allman et al., 1993; Robins et al., 1959), the psychological autopsy has been the key diagnostic factor in scrutinizing completed suicides. Its development can be charted from a primary interview with two psychiatrists making a diagnosis to a complex, multi-disciplinary team effort including efforts of police and social agencies, families, friends, and health contacts. The groundbreaking investigation of suicide by Robins et al. (1959) educated a generation of scientists in fundamental reasons behind this act of self-destruction through the innovation of the psychological autopsy.

The concept of the psychological autopsy allowed objectification and quantification of the suicide act. Psychiatric disorders and substance abuse could now be viewed objectively as key factors for those who consider suicide as a coping mechanism (Brent et al., 1987; Pages et al., 1997). Psychological autopsies identified as many as 90% of adolescent suicides with psychiatric disorders (Bukstein et al., 1993). The severe psychopathology of psychotic disorders (6% to 15%) was the extreme in adolescents committing suicide (Fowler et al., 1986; Kotila & Lonnqvist, 1989; Marttunen et al.,

30

1992) while other suicide completers demonstrated no apparent psychopathology (Brent, Perper, Moritz, Allman, Baugher et al., 1993). Affective disorders were frequently diagnosed (50%) in completed suicides (Bukstein et al., 1993; Kotila & Lonnqvist, 1989; Marttunen et al., 1992). Gender differences (79% for females and 59% for males) were highly significant (Marttunen et al., 1995).

Studies have demonstrated that overwhelming life stressors can contribute to the suicidal act by use of alcohol as a disinhibiting coping mechanism (Marttunen et al., 1994). Alcohol disorders were the most common disorders seen in adolescent suicides whether as a primary or comorbid diagnosis. Alcohol use (up to 83%) was equated with suicide and violent death, predisposing youth to early death (Brent et al., 1987, 1998; Bukstein et al., 1993; Kotila & Lonnqvist, 1989; Marttunen et al., 1992, 1995). Alcohol was highly associated with suicidal intent (14% to 94%) and predisposed youth to suicidal ideation and attempts (Brent et al., 1987; Brent, Perper, Goldstein et al., 1988; Brent, Perper, Mortiz, Allman, Baugher et al., 1993; Bukstein et al., 1993; Kotila & Lonnqvist, 1989; Marttunen, 1992, 1995). Substance abuse is without question highly self-destructive and, in itself, suicidal (Menninger, 1938). It has been overwhelmingly associated with violent death by firearms in suicides (Brent, Perper, Goldstein et al., 1988; Brent, Perper, Moritz, Allman, Baugher et al., 1993; Bukstein, 1993; Marttunen et al., 1995) and all types of violent deaths (CDC, 2009c; Kotila & Lonnqvist, 1989).

Suicidologists are concerned about the lethal affinity between alcohol and the adolescent suicidal event (Brent, Perper, Goldstein et al., 1988). Current alcohol use in completed adolescent suicides was determined to be between 21% and 83% (Brent et al.,

31

1988; Bukstein et al., 1993; Kotila & Lonnqvist, 1989; Marttunen et al., 1992, 1994,

1995). Intoxicated adolescents were more than 7 times likely to use a firearm to commit

suicide than those victims not under the influence. Adolescent males were most

frequently under the influence of alcohol at suicide (Brent et al., 1987). Research has

documented a steady increase in post-mortem blood alcohol levels corresponding with

the escalating adolescent suicide rate in the U.S. Alcohol was a significant precursor to

violent death whether by suicide, homicide, or traffic fatalities (CDC, 2009c; Kotila &

Lonnqvist, 1989). The relationship of alcohol to violent death was inversely proportional

to the psychiatric care received by the victims. Most adolescent suicides, prominently

violent suicides (firearms or hanging), were committed by males, yet males received

significantly less frequent psychiatric intervention than females (Kotila & Lonnqvist,

1989; Marttunen et al., 1995). Even definite communication of suicidality did not result

in care for half of the adolescent suicides in one study (Marttunen et al., 1992).

Nevertheless, psychosocial stressors are often equal between genders, yet

depression is higher in females (Bukstein et al., 1993; Marttunen et al., 1994, 1995).

Females decidedly completed suicide at lower rates than males. Adolescent females have

more severe characteristics leading to suicide. Substance abuse was also a key element in

their suicides. A majority of adolescent females chose the least violent methods of suicide

(overdoses, lacerations, or carbon monoxide poisoning) regardless of the fact, or perhaps

in despite of knowing, that these methods are commonly acknowledged to have a higher

rescue potential. This lower lethality choice is thought to contribute to the higher attempt

rate, yet lower completion rate, in females (Marttunen et al., 1995). Despite this, some

women who contemplate their death will ultimately follow through.

Chapter III

Method

A portion of this chapter serves as a guide to the qualitative research method that includes a description of and rationale for the case study as an appropriate method for investigation of a phenomenon such as near-suicide. The criteria and limitations of the method are reviewed. Essential details of the study including sample with inclusion and exclusion criteria, instrumentation to measure lethality of suicide attempts, description of the site, and study and interview protocols are presented. The role of the investigator in qualitative study is examined. Protection of human subjects, specifically the vulnerable populations of adolescents and hospitalized mental health patients, is detailed.

The reader is provided with a description of the research facility and its significance for this problematic event. The sample and instrumentation for selection of the sample are reviewed including a description of the data collection method, consents, and protocols for the study and interviews. The imperative of protecting the human subject in this controversial issue are addressed. The criteria for qualitative research review are delineated.

Rationale for the Research Design Approach

Rationale for the Qualitative Research Approach. A qualitative study focuses on the complexities of human behaviors (McGloin, 2008). Qualitative research compiles data through observation and immersion in the events under examination. It immerses the

investigator and the reader in this phenomenon in an attempt to allow the reader to appreciate and value the experience. Its aim is to collect and collate the rich, vivid data resulting from this method of inquiry.

Through the content analysis of qualitative research, the data from these seemingly inexplicable human behaviors can be focused and distilled further into essential elements (Hutchison & Webb, 1989). It analyzes this data for shared meanings, patterns, and values among the subjects. The current study endeavored to delineate the phenomenon of near-fatal suicide in adolescents to further understand this experience and contribute to nursing theory-building. This qualitative study can supplement the body of knowledge of suicide prevention.

To enhance the credibility and dependability of the conclusions, the qualitative research method begins with the investigator's acknowledgment of any personal bias or ulterior motive during the process. Such a statement serves to advise the reader of any predisposition on the part of an investigator to obtain particular responses. The outcome of the study is to be affirmed by the investigator to be without misrepresentation, intentional or otherwise (Vidich & Lyman, 1998). The narratives of the experience must be affirmed by the investigator to be without alteration or distortion. This is the same skill required of the nursing student, that is, to begin to relate and understand the problem through the perspective of the patient. It was the intention of the investigator to examine this difficult experience to demonstrate the strength of the investigator's commitment to this important issue in suicidology (Lincoln, 2002) and refusal to accept obstacles inherent in the study of adolescent suicide.

35

Rationale for the Case Study Method. The case study examines a *case, or unit*. A unit for analysis can be the case of an individual, a group of individuals, or even a phenomenon for analysis. Case studies rely on conducting in-depth interviews with subjects, reading and analyzing journals, diaries, records offered by the subject, and the investigator's field notes (Stake, 1995). This case study proposes to examine the phenomenon of the near-fatal suicide attempts by seven adolescent females. It consisted of the lethality assessment of the attempt, audio-recordings and the verbatim transcriptions, an initial psychiatric evaluation and history as well as the histories of the subject's family, medical and psychosocial histories, field notes and the many analyses of the subjects' transcriptions and notes in the margins.

Qualitative research develops a collective *voice* of the experience under study. This study sought to provide rich, personal descriptions of the adolescent perspective. In selecting a case study method, this investigator hoped to hear the true thoughts and emotions in the stories of adolescents who made near-fatal suicide attempts. It was hoped that presenting this collective data would aid in the diagnosis and treatment of the suicidal adolescent and add to suicide prevention efforts. After working with adolescents for more than twenty years, this investigator has dealt with the issue of the suicidal adolescent voice almost on a daily basis. The case study method was chosen in order to understand in-depth why adolescents make such lethal attempts. The qualitative narrative and its content analysis has been integrated into quantitative research to enhance validity of the objective data through the subjective lens (Freyberg, 2009).

36

This case study method afforded the opportunity to adequately describe to the reader the turmoil in which the subject made the decision to die. This compelling research phenomenon and its relevance to human behavior were the foundation of this case study. As with all case studies, it intentionally isolated a particular subject population. In this study, the targeted population was the near-fatal adolescent suicide attempter. Case study methodology lends itself to the retelling of these distressing emotions that surrounded the subject's decision to choose suicide. It vividly illustrated how suicide was viewed as the *best solution* to the perceived intolerable pain (Maris, Berman, & Silverman, 2000). The case study was an influential and focused instrument for investigation of this phenomenon. It was targeted to avoid irrelevant information and each case was dealt with individually. This strengthened the possibility of the cross-case conclusions and patterns that emerged during analysis.

The qualitative investigator should, and did, have a *significant* foundation of knowledge in the subject matter. This starting point supported a more accurate assessment and analysis and contributed to credibility and dependability of outcomes. In the current study, even a thorough understanding of family dynamics and communication and adolescent development would not have been sufficient to assess for patterns in these suicide attempts (Shemanski-Aldrich & Cerel, 2009). The investigator's knowledge base closely correlated with specific understanding of the suicidology of the adolescent for in-depth analysis. The data were obtained, reviewed, and analyzed by investigators with a significant understanding of the of the phenomenon under study which then correlated to credibility (McGloin, 2008; Patton, 1990; Ryan-Nicholls & Will, 2009).

A lesser though important point was the vitality in the story. This quality goes beyond the analysis in bringing more humanity to this phenomenon. This type of compelling and rich narrative has the potential to reach a larger audience than the professional discipline for which it was intended.

Description of Research Site

The research site was a 700-bed suburban hospital. Staffed entirely by board-certified physicians and an all registered nurse (R.N.) nursing staff that received a national award for nursing excellence, it serves 50,000 patients annually. The 14-bed adolescent psychiatric unit served a 3-county cachement area of the state. Hospital policies and regulations governed the standard of care for the suicidal adolescent. After medical stabilization and clearance, adolescents with near-fatal suicide attempts were generally admitted from one of two children's hospitals in the area. The suicidal adolescent was placed on suicide watch and any other pertinent precautions as determined by the psychiatrist or advanced registered nurse practitioner (A.R.N.P.) upon admission to the locked adolescent unit. An R.N., specialized in child and adolescent psychiatry, assessed each adolescent upon admission. The adolescents were encouraged to participate in unit activities such as group therapy, art therapy, and gym activities.

Protocol dictated an initial psychiatric evaluation by the attending psychiatrist and the A.R.N.P. that included a physical examination. Pediatric consults or other medical consults were ordered as needed for pertinent medical issues or follow-up after the suicide attempt. There were daily psychiatric evaluations by the attending psychiatrist and A.R.N.P., an initial family therapy evaluation with the unit family therapist, and

referrals for family therapy as needed. Adolescents at risk of suicide could not be discharged from the hospital.

Hospital procedures dictated all adolescents be referred to outpatient therapy for counseling and psychiatric follow-up. After successful psychiatric stabilization, the discharge planning was coordinated through the attending psychiatrist and family therapist. This included appointments with the psychiatrist and A.R.N.P. for follow-up evaluations, new and/or continued medication prescriptions and any individual and/or family therapy appointments. The R.N. coordinated the discharge sequence including parental review of medication prescriptions and plans for psychiatric follow-up.

Sample

Purposive sampling of inpatient adolescent suicide victims was utilized for this study. The population for the study was determined by evaluation with the Risk-Rescue Rating Scale for Suicide Attempts administered by the study psychiatrist. Those adolescents who scored 50+ points on the scale were determined to have made a near-fatal suicide attempt. The study psychiatrist was also responsible for the evaluation of the potential subject based on his experience and expertise as a board-certified child and adolescent psychiatrist. A purposive sampling was necessary due to the small numbers of near-fatal suicide attempts by adolescents and adults, especially among males. Males complete suicide at significantly higher rates than females who attempt suicide at significantly higher rates than males. This discrepancy, in all likelihood, is because statistically males use more lethal means—usually a firearm or by hanging—than females

thus succeeding at higher rates (Brent et al., 1987; CDC, 2009c, 2010; Kotila &

Lonnqvist, 1989).

The study site and circumstances were dictated by the study protocol. The

psychiatric hospitalization insured the safety of the subject during crisis stabilization and

neuropsychiatric evaluation as well as during the subject's participation in the study.

The psychiatric hospitalization was to insure crisis stabilization, neuropsychiatric

evaluation and family intervention prior to outpatient referrals. Recruitment was initiated

by the study protocol's psychiatrist who is board-certified in child and adolescent

psychiatry and adult psychiatry. The child and adolescent psychiatrist first spoke with

parents to request that the principal investigator be allowed to discuss the possibility of

their child's participation. If in agreement, the principal investigator explained the study

and informed consent was obtained. The adolescent was then approached to discuss the

study and possible participation. After a 24-hour waiting period, during which the family

was encouraged to confer with a knowledgeable third party (i.e., a pediatrician or private

psychiatrist), informed assent was obtained from the adolescent.

Criteria

The transition between childhood and adulthood—adolescence—in human

development has signified important changes in cognitive abilities and sexual

development. During this period, identity, role, and independence have evolved (Baron &

Sholevar, 2009; Erikson, 1959, 1968). The length of adolescence varies greatly among

individuals since it is determined by completion of the developmental tasks. Adolescence

begins at puberty (approximately age 12) and delays in task completion can prolong

maturation into early adulthood. Early adulthood, defined as independence, can be accomplished at many ages (Berman & Jobes, 1995). For the purpose of this study, adolescence was defined as ages 13 to 18 years.

Inclusion Criteria. The inclusion criteria consisted of any adolescent between the ages of 13 and 18 years who a) attempted suicide with high intentionality and low rescuability and b) had a sucide attempt that met a level of lethality considered serious/near-lethal on the Risk-Rescue Suicide Assessment Scale (Weisman & Worden, 1972) or as determined by the study psychiatrist who was board certified in child and adolescent psychiatry.

Exclusion Criteria. The exclusion criteria consisted of (a) being unable to communicate in English, (b) being younger than age 13 or greater than age 18, or (c) being in the state foster care program. The reasons for these exclusion criteria were due to the nature of the study, which relied on significant descriptive accounts, and were due to the fact that the principal investigator and study psychiatrist spoke only English; thus subjects who were not fluent in English could not be included in the present study.

Instrumentation

Risk-Rescue Rating Scale for Suicide Attempts. The type of suicidal behavior examined in this research was the high risk-low rescue suicide attempt. This connotation refers to the combination of the lethality of the high risk method such as a firearm or hanging, with the low rescue probability such as driving to a secluded area, waiting until members of the household are expected to be gone, or not reporting the attempt to

41

anyone. This type of suicide attempt is significantly more likely to result in death and is usually so intended.

The severity of the attempt was assessed using the Risk-Rescue Rating (Weisman & Worden, 1972) which delineated *gesture* from *serious intent to die.* The 10-item interviewer-administered instrument required about ten minutes to administer and score. Its design was intended to assess lethality and intent of the suicide attempt with ten items measuring risk level and rescue potential. Each had a specific value for a possible high score of 83 on the scale.

Factors involved in evaluating the risk of completing the suicide included the suicide method, the extent of damage or toxicity sustained on the level of consciousness, the expected degree of recovery, the expected reversibility, and the degree of required medical intervention. Rescue potential factors measured the circumstances of discovery. These involved the probability of discovery of the attempt due to its location, important for determining lethality, and locale, important in determining whether the discovery was certain to occur; and who initiated the rescue after discovery. Locale also determined any delay in time to discovery, also an important criterion for rescue (Weisman & Worden, 1972). The criteria and rating scores for risk and rescue assessments are shown in Tables 1 and 2, providing a more comprehensive explanation.

Table 1.

Risk Factors for Suicide Attempts

Risk Factor	Low Lethality	Moderate Lethality	High Lethality	
Method	Poison, Laceration	Drown, Hang	Jump, Gun	3
Consciousness	No Harm	Confused	Coma	3
Lesions/Toxicity	Low	Moderate	High	3
Reversibility	Total	Likely	Long-term Effects	3
Treatment Req.	First Aid	Hospitalization	Critical Care, ICU	3
Points	1 each	2 each	3 each	15

Note. Rescue ratings assess the probability of the risk to completed suicide from least likely to highly likely. Adapted from "Risk-Rescue Rating in Suicide Assessment," by A. Weisman and J. Worden, 1972, *Archives of General Psychiatry, 26,* 553-560. Used with permission. Copyright © 1972. American Medical Association. All rights reserved.

Table 2.

Rescue Factors for Suicide Attempts

Risk Factor	Low Lethality	Moderate Lethality	High Lethality	
Location	Home or Close	Neither	Isolated	
Rescuer	Relative, Friend	EMS	Bystander	
Discovery	Almost Certain	Uncertain	Accidental	
Rescue	Asks for Help	Drops Clues	Does Not Ask	
Delay to Rescue	Less than1 hour	1-4 hours	More than 4 hours	
Points	3 each	2 each	1 each	15

Note. Rescue ratings assess the probability of the rescue from a completed suicide from least likely to highly likely. Adapted from "Risk-Rescue Rating in Suicide Assessment," by A. Weisman and J. Worden, 1972, *Archives of General Psychiatry, 26,* 553-560. Used with permission. Copyright © 1972. American Medical Association. All rights reserved.

An adequate inter-rater reliability, or physician agreement, is reported for the Risk Rating (kappa = .67), with 12.9% of the physicians disagreeing on risk categories (Potter et al., 1998). However, Potter et al. (1998) reported the inter-rater reliability of the Rescue Rating was lower (kappa = .59), with 22% of the physicians disagreeing on the rescue rating (Potter et al., 1998).

In concurrent validity, the Risk-Rescue Rating is moderately correlated ($r = .60$) with the Beck's Lethality Scale. A high degree of intra-rater reliability on method was found between the Risk-Rescue Rating and the Self-Inflicted Injury Severity (kappa = .88; Potter et al., 1998). The Risk-Rescue Rating discriminated between those who survived and did not survive. It did not distinguish between those who had never attempted and those who had attempted multiple times (Weisman & Worden, 1972). In another study, high scores on the Risk-Rescue Rating were positively associated with high scores on the Suicide Intent Scale ($r = .38$; Goldney, 1981). In conclusion, the inter-rater reliability of the Risk-Rescue Rating is well established. There is respectable concurrent validity of the measure with other ratings of self-injury (Brown, 2002).

Description of Data Collection Method

Procedure for Informed Consent and Assent. Both the study site hospital and university Institutional Review Boards approved the procedures for this study. The procedure for obtaining informed consent from the parents/guardians and informed assent from the adolescent was designed to provide sufficient time for reflection and, if needed, withdrawal from the procedure and study. Adolescents and parents/guardians were given time to consider the information about the research protocol. A built-in waiting period within the consent/assent process was intended to stress the importance of fully comprehending the nature of such a potentially emotional subject. This also allowed potential participants an opportunity to consult with other family members or trusted professionals, such as a pediatrician, about whether or not to participate.

The hospital-assigned attending psychiatrist referred individuals who met the inclusion criteria of adolescents aged 13 to 18 years who had been admitted to a locked adolescent psychiatric unit after a suicide attempt. The referrals were made to the study psychiatrist to protect the privacy of individuals. The study psychiatrist determined the level of lethality of the suicide attempt and the rescue potential of those subjects referred for recruitment. Parents/guardians were initially contacted by the study psychiatrist to further protect the individual's privacy. Their permission was sought to discuss possible recruitment of their adolescent into the study. Informed consents were first obtained from all parents/guardians. After consent, the adolescent was then approached to discuss the study either in the presence of the consenting adult or later, without the consenting adult present, whichever was preferred by the parents/guardians. In the privacy of an office on the unit, the research was explained to the adolescent. If acceptable, informed assent was obtained the following day.

Protection of Human Subjects. Human subject safety was of paramount consideration as in any research endeavor. Few studies have been designed to address suicidality due to concerns for severe adverse outcomes such as a suicide. Consequently, research with adolescents who have recently made near-fatal suicide attempts is virtually non-existent. Unsatisfactory safety monitoring was frequently cited as an explanation for not working with suicidal adolescents or other vulnerable groups. According to many sources, the potential risks of suicidal crises outweighed the benefits of this type of study. Fundamentally, a perception of liability has produced significant apprehension for

46

conducting research into these issues. Safety monitoring, ethical, and legal concerns relevant to suicidology have hindered the study of individuals at high risk for self-harm (Pearson, Stanley, King, & Fisher, 2001).

The investigators integrated objectives from the National Institute of Mental Health (NIMH) into the protocols to enhance risk management of the suicidal individual. These objectives included developing essential criteria in protocols on (a) withdrawal from the study for any increase in suicidal ideation, (b) hospitalization of a suicidal individual, and (c) determination of any increased risk with the identification of means to commit suicide. A high level of expertise among the research personnel is considered a critical component. This included specific training for research staff in managing the hospitalized individual and for enhancing their comprehensive knowledge of the protocols, such as how and when to report adverse events. Discussions with parents and subjects concerning the limits to confidentiality regarding expressed suicidal ideation were conducted to alleviate anxiety pertaining to safety. Parents were assured that the adolescent's safety was critically important to the research team, especially if the adolescent expressed suicidal ideation (Pearson et al., 2001).

The current study's protocol as approved by both the hospital and university institutional review boards addressed these issues and others to broaden participant protection. The research personnel were highly qualified professionals. The study psychiatrist, board certified in child and adolescent psychiatry, has more than 20 years of experience working with this population on an inpatient and outpatient basis. He has also

served as the chair of the department of psychiatry at the study hospital and medical

director of the adolescent psychiatric unit for more than 10 years. The principal

investigator was an A.R.N.P. with more than 10 years in inpatient and outpatient practice

with the study psychiatrist. The principal investigator previously worked with acute

psychiatric inpatient adolescents for 16 years. She spent eight of these years at the

University of Texas Medical Branch (UTMB), Galveston, Texas on the inpatient child

and adolescent psychiatric units while working with fellows in UTMB's child and

adolescent psychiatry residency program.

It was important to communicate to participants that this study was not designated

as treatment or intervention. Participants were clearly informed that there were no

anticipated direct benefits of study participation. The research focus was to enhance

knowledge toward prevention efforts only. They were informed of the possibility that the

improved understanding gained from this research might guide the clinical practice of

mental health professionals and contribute to further research on treatments and

interventions to reduce suicidality in others.

For subject and parental protection, emphasis was placed on the right to terminate

participation at any time during the study. They were assured that their decision to

terminate involvement would be handled ethically without question. All referrals for

recruitment were made to or by the study psychiatrist to protect privacy in accordance

with HIPPA regulations. Only after the study psychiatrist contacted the family for

permission was the principal investigator involved to obtain their informed consent.

Participants were encouraged to inform a third party of their participation for increased monitoring and provided with a 24-hour direct contact number for assistance questions, concerns, or emergencies. There was no compensation provided for study participation. Participants were informed that audiotapes would be destroyed in accordance with study protocol and both the hospital and university institutional review boards' policies. Consents and assents noted all the above information. All parents/guardians signed informed consent. All adolescents signed informed assent.

The subject's participation was to begin only after crisis stabilization. To further protect the subject and determine emotionality and suicidality, the child and adolescent psychiatrist met privately with each subject pre- and post-interview. These evaluations were to determine, in the psychiatrist's professional opinion, whether or not the adolescent's participation in the study was causing undue risk, or evoked any suicidality.

Study participants were informed of serious, although unlikely, risks inherent in the suicidal individual such as the risk of a suicide attempt or a completed suicide. They were also advised of possible minor complications including sleep or appetite disturbances and changes in mood. Study participants were informed that in the case of imminent suicidality, research or nursing staff would assure immediate and appropriate care for the individual. They were assured that increased suicidality or any adverse event would be immediately reported to the study psychiatrist and the safety monitoring boards for both the hospital and university institutional review boards. The investigator was acutely aware of the need to withdraw a subject from the study if increased suicidality or

49

related symptoms developed during the study course. Each subject was observed at all times prior to, during, and after the study interview, and through discharge as per unit protocol. Any concern would have been cause for termination to protect the subject as specified in the study protocol.

At discharge, hospital policies dictated all subjects be referred to outpatient therapy for counseling and psychiatric follow-up. (For the protection of any patient, hospital policy dictated that an adolescent at risk of suicide may not be discharged from the hospital.) In accordance with study protocol to advocate for safety if a subject was perceived to be at increased risk to develop emotional disturbances, the subject was to be offered additional referrals. These referrals for continued treatment, at no expense to the subject if needed, included psychiatric follow-up and individual/family therapy with the study's child and adolescent psychiatrist and A.R.N.P.. Referring and attending psychiatrists also agreed to participate in this option, if requested.

Interview Protocol. Interviews to collect data were conducted in a private office on a locked psychiatric unit. Each subject's interview lasted approximately 20 to 30 minutes. As previously indicated, the study psychiatrist conducted pre-and post-interviews to evaluate emotional stability to proceed and any possible suicidality that would be detrimental to the subject. The pre- and post-interviews consisted of the study psychiatrist's assessment of the mental status of the subject, according to learned, professional criteria for emotional stability and suicidal ideation.

The study interviews were audiotaped for transcription by a certified medical transcriptionist employed at the hospital (compensated by study funds). Audiotapes were labeled with a number only, ranging from one to seven for each of the seven participants. No identifiers such as the subject's or family member's name or high school were used during the taping to prevent inadvertent identification of any subject. Subjects were reminded that a request for termination of the interview could be invoked without question at any time and that the audiotape would be destroyed.

Study Protocol. The psychiatric interview facilitated, rather than inhibited, communication in the telling of the lived experience of a near-fatal suicide attempt. The interview was conducted with general, open-ended questions targeted toward eliciting precipitating emotions or factors, but allowed the subject to discuss what she felt was important about the event. This interview technique facilitated a rapport to collect valid data and develop a progressive understanding of the subject (Shea, 1988). Trust and safety were prominent in exploring and sharing the intense emotions of the subject.

These private interviews with only the subject and principal investigator present lasted approximately 20 to 30 minutes each, depending on the individual. However, subjects were not hurried or cut short in the relating of their experiences. Subjects were merely asked to describe their thoughts, feelings, or events that led to their suicide attempt. Only non-directive promptings such as "What were you thinking prior to your attempt?" or "Can you tell me about how you were feeling prior to your attempt?" or "Can you tell me more about that?" were given by the principal investigator to lessen the

impact of leading the individual to any investigator-biased issues.

Qualitative Research Criteria

Credibility. Credibility, or internal validity, of the study was concerned with the degree to which the research measured the intended phenomenon as indicated. In obtaining this validity, this qualitative study used several techniques in data gathering. The prolonged interview coupled with observation of the subject increased the likelihood that credible findings would be obtained. Validating data with an outside qualitative investigator, also enhanced the credibility of the results.

The validation of data analysis with the outside qualitative investigator was an important criterion for determining credibility in this qualitative study (Lincoln, 2002). It provided an opportunity to assess whether the data collected responded to the research intention. An outside qualitative reseacher analyzed the interviews for content and resulting issues. In this study, the outside qualitative researcher was a dissertation committee member. This review involved reanalysis of the interviews for credibility, coding categories, interpretations and conclusions. The two then met for the opportunity to compare, contrast, challenge, and reconcile any findings.

To further credibility, the psychiatric method of interview enhanced communication in allowing the subject to talk of the experience as was most comfortabe for each of them. Prolonged engagement with the subjects increased the scope of the data obtained. The goals of such an interview were to establish a rapport, collect valid data, and develop a progressive understanding of the event (Shea, 1988).

Establishing a rapport inherently meant trust and safety to explore and share feelings. This rapport began with the investigator's view that the interview was important to both the investigator and the subject. The investigator should project concern and sincerity as well as genuine acceptance of the subject and her emotions regarding the event. Gaining trust encourages the subject to express her feelings.

Another criterion to establish credibilty is the objective concentration on individual responses of the subject. This is needed for the investigator to "discriminate subtle differences in the personal and psychological states of others" (Lincoln, 2002, p. 337) and identifies any contradictions presented in the subjects' stories.

The final test of credibility is that those who read this study will recognize the description as credible based on personal experience, or will recognize the experience, should it happen to them or significant others, from having read the description (Patton, 1990).

Dependability. Dependability is the qualitative investigator's criteria for consistency of results. This was facilitated by an outside qualitative investigator examining the actual process of drawing conclusions and the end-product of those conclusions. Dependability was enhanced with validation through the paperwork of the analysis. This *audit trail* consists of recordings, transcripts, transcription coding, notes in margins of interviews, field notes, medical histories, psychiatric evaluations, test results, or other investigator-generated work. In future research efforts, this *audit trail* can be used by an outside qualitative investigator to evaluate the quality of the analysis. This

paperwork assists the future qualitative investigator in rechecking results and demonstrating dependability of the process.

Eloquent qualitative data for analysis begins with the commitment to refrain from directing or distorting the interviews to fit preconceived philosophies or viewpoints. Not only does this cause considerable bias and possibly transform outcomes, it subtly informs the narrator of this important story that their one true experience is not valued. The idea of the interview is to reveal the inner experience the investigator cannot live and, therefore, cannot know. Interviewers must begin the straightforward retelling of these lived experiences. This entailed allowing the narrators to choose the words because this free expression can communicate meaningful descriptions and vignettes of their own experience. They are the experts of their own experience.

This investigator contributed to the dependability through qualifications, professional experience, and daily contact with suicidal adolescents over many years. The investigator's qualifications include degrees in nursing and journalism, and an advanced degree in psychiatric-mental health nursing. Additionally, the dissertation coursework was tailored to the psychiatric-mental health issues confronting the subjects and this nation and most work was geared toward suicide. The investigator has spent nearly every day of her career working with the suicidal adolescent. This entailed initial psychiatric evaluations and daily follow-up visits in the acute care setting of the hospital. It also included conducting individual, group, and family therapy on a regular basis. The investigator also worked as a graduate research assistant on an NIH grant to study

adolescent suicide. In this capacity, the investigator reviewed over 300 charts of autopsies

of adolescents who had committed suicide in the surrounding area in the present study.

Each one contained numerous photographs of the victims after death that could not be

avoided being seen by the investigator. These and other experiences with suicidal

adolescents prompted this line of research and, ultimately, this study. The experience in

journalism has enhanced the investigator's desire for truth and disclosure, but tempered

by the nursing professional's understanding of caring and confidentiality.

   Transferability. Generalization is an important impetus in science. It assumes that

all entities measured are uniform, each unit of the entity studied share the characteristics

of the whole, and that each entity studied can then be defined for purposes of

extrapolation (Johnson, 1977). Generalizations are "broad statements based on limited

information" (Johnson, 1977, p.193). Quantitative investigators find fault with the

qualitative methods by viewing the inferences as ungeneralizable, and thus of little value

to the phenomena studied or to science.

   However, even quantitative research can fail to generalize. To illustrate, in

quantitative studies of completed suicides, Brent et al. (1993) found multiple adolescent

suicides with no apparent psychopathology, clearly incongruent with the body of his

research. In the majority of studies on completed suicide, the psychological autopsy

retroactively constructed a psychiatric profile of a patient never interviewed (Dougherty,

2007). Most suicidologists would concede that there is no universal commonality among

completed suicides (Shneidman, 1985/2004).

Guba (1981) coined the term *transferability* to suggest the concept of generalizing findings. That is, through understanding both the project and information gained in particular qualitative research and the subsequent framework or environment to which one wishes to transfer this knowledge, one can generalize. It is the typicality or representativeness of a phenomenon. Frequently, qualitative investigators use consensual validation (Johnson, 1997), that is, the consensus by outside qualitative investigators of the current inferences.

Generalizability in qualitative research can be strengthened when current conclusions correlate with, or transfer to, other research conclusions (Morse, 1992). It is the rich, vivid description of phenomena that can capture the imagination. Qualitative research immerses the investigator and reader in the phenomenon allowing others to experience and to understand.

The transferability of findings is limited by sampling methods and environment. These issues are taken into consideration during analysis and discussed in results. Transferability is dependent on the resemblance of the phenomenon and the environment to that with which it is being compared. The investigator assumes responsibility to provide a sufficient amount of description that may be needed for future investigators to decide if it is functional in their situation. In the current study, a purposive sampling of every near-fatal suicide attempt admitted to the adolescent unit was necessitated by the infrequency of such attempts. This infrequency is evident in the sample size of seven

56

subjects. In comparison, there were more than 400 admissions to the study's psychiatric unit during the same timeframe.

Framework for the Content Analysis

The analysis in this study was based on Burnard's (1991) framework for organizing substantial amounts of data, particularly interviews, in qualitative research (Gonzalez & Lengacher, 2007). Burnard described a 14-stage process for content analysis. This process systematically refined the data in steadily broadening categories. Much of this process produced the audit trail for examination and verification of the process by other qualitative investigators and for any later inquiries.

Step 1: Note Making. The beginning step allowed the investigator to review the interviews as they were transcribed and to review audiotapes for accuracy. Field notes immediately after the interviews detailed small thoughts and ideas that came to the investigator as the subjects spoke. Notes were made of focal issues as they were identified. Relevant statements regarding suicidal ideations were noted.

Step 2: Immersion in the Data. This phase re-examined the volumes of transcripts. Previous notes were reviewed and reworked. The focus was on the issues that transpired in the interviews and recurring themes expressed by the adolescents.

Step 3: Open Coding. Themes, or patterns, that were emerging from the data were expressed in coding by the investigator. The coding scheme was generated from the language of the experience. Patterns developed from snippets of the conversations and subsumed into ever more encompassing themes.

57

Step 4: Development of Broader Categories. It was at this stage that final themes were beginning to surface in the voices of these resolute adolescents. Virtually hundreds of quotes revealed similarities that were encompassed into still broader categories.

Step 5: Refinement of Categories. This was a process of total immersion into the dialogues on paper. Quotes were read and reread to continue refinement into even broader themes. These were the times when the statements reverberated in the investigator's thoughts throughout the day.

Step 6: Guarding Against Bias. To avoid the partiality that can occur with immersion in such emotionally charged data, another qualitative investigator reviewed the emerging themes for coherence. The outside qualitative investigator reviewed the data in a similar manner to extract focal issues and then compared findings. This portion of the research lends credibility to the original work when parallel. The investigator was also continuously introspective regarding the phenomenon and the participants.

Step 7: Establishing that Categories Cover All Aspects of the Interviews. To ensure no part of this lived experience escaped attention, data were reread to further scrutinize for thematic content. This process affirmed reliability of previous suppositions.

Step 8: Code Data into Identified Categories. The continuing data content analysis examined the coding of the broadest themes. Re-consulting transcripts assisted in reevaluation of themes/categories for congruence. It also allowed for reflection on the phenomenon from a new perspective.

Step 9: Further Coding into Identified Categories. Category identification is an ongoing process of data analysis that continually immerses the investigator in the phenomenon under study. With thematic appraisal nearing completion, content of the interviews were matched with themes to convey the reality of the experience.

Step 10: Individual Analysis. Each interview was explored to determine the focal issues for each individual participant in experiencing this phenomenon. This helped the investigator to feel with certainty the living emotions that were within the quotes. It began to give meaning to their sharing.

Step 11: Checking Validity/Credibility. This is an important criterion for qualitative research. Objective and realistic examination of strengths and weaknesses is imperative to instill value in this research method (Burns & Grove, 2003). In this respect, prolonged contact captured significant amounts of data which authenticated the experience. However, due to important considerations of the nature of the phenomenon, recontact with the adolescents was not made. Themes were reevaluated for congruence to check credibility. Frequently, the qualitative investigator has the participant review the individual data to obtain concurrence. However, this was not possible due to the design of the study protocol which called for pre- and post-interviews with the study psychiatrist. Additionally, the participants had usually been discharged home within a week.

Steps12 -14: Organizing and Writing Up the Data. Familiarity with the tenets of suicidology and a long professional career working with adolescents in similar situations provided invaluable understanding in deciphering thematic content. Yet, the inductive

process in this methodology contributed to a deeper comprehension of the experience. It instilled high regard for the process as arduous as it was.

Drafting the write-up is a further step in this process described by Burnard (1991). The clarification of themes, rereading of interviews, and reexamination of available literature for both the study and its design assists in the writing of the research.

Role of the Investigator

"The investigator is the instrument in qualitative inquiry" (Patton, 1990, p. 472). Therefore, the qualifications and perspectives of the investigator/investigator are of considerable importance in all aspects of the study. The investigator is obligated to report any particular information that may affect data collection, analysis, or interpretation, according to some qualitative experts (Patton, 1990). Questions to be asked include: *Did the investigator allow personal biases to surface during the subject's interview? Was the investigator emotionally involved to the point of clouding the issue? Did the investigator have a hidden agenda?*

The presence of the investigator does affect the research whether qualitative or quantitative. The investigator can distort or enhance research data through findings and write up. The investigator must be highly competent in the research discipline, any biases or changes in the investigator must be addressed, and the reactions of participants and peripheral persons to the investigator must be noted. Reciprocity is another highly important criterion since the investigator must acknowledge the ultimate impact of her presence on the discourse (Lincoln, 2002).

Patton (1990) noted that the presence of an investigator cannot be overrated or underrated in conducting research. The investigator has a crucial responsibility to be well-trained, fair-minded, empathetic and responsive, and to minimize possible distortions to the work through diligent self-monitoring. The investigator is cautioned to remain professional and avoid personal involvement. An empathetically neutral and impartial position while maintaining a caring and responsive demeanor is imperative for trustworthiness, credibility, and internal validity of findings.

Summary

A review of the qualitative method embraced in this research was presented. The reasoning and analysis of the case study were presented to promote an understanding of qualitative research methodology and its relevance in this important subject. Issues such as qualitative research method, definition of the case study, selection and protection of subjects, and definition of terms were delineated. The criteria for analysis of qualitative research and its limitations, both real and perceived were discussed. This chapter served as a methodological guideline for this study of adolescent suicide, a critical issue of our time.

Chapter IV

Results

The results of the data analysis are presented in this chapter. The sample

consistency, the selection criteria, and instrumentation are discussed. An analysis of the

interviews with the suicidal adolescents and patterns that evolved are presented. The

study is analyzed with qualitative research criteria and the results summarized.

A purposive sample of seven Caucasian adolescent females were recruited for

participation in the study after a near-fatal suicide attempt by poisoning. Each attempt

was rated near-fatal as indicated by the Risk-Rescue Rating Scale measuring suicide

attempts in terms of lethality of risk and potential for rescue. An open-ended interview

technique encouraged candid expression of adolescent emotions and understanding of

events surrounding the attempt. Burnard's method of thematic content analysis of these

interviews revealed the collective adolescent voice. The words of these subjects were

quoted to reveal the depths of emotions and illustrate the themes.

A model was constructed based on this content analysis. The model of a path of

an adolescent near-fatal suicide attempt authenticated the estrangement and eventual

alienation experienced by the subjects. Contributing to the pathway was the subject's

experience of estrangement from the two most important social support groups for

adolescents—parents and peers. It became apparent that these subjects experienced a lack

62

of self-identity to cope with stressful experiences in a more rational manner. Parenting issues contributed to the pathway. Parenting skills were highlighted by the subject's perceptions of non-supportive communication. Furthermore, parental role modeling proved ineffective for these subjects. Parents were unsuccessful in setting age-appropriate limits with the subjects.

Peer issues emerged as the subjects' perceived a lack of social support by their peer group. Important aspects were characterized by perceptions of peer rejection and ridicule. Coupled with the impulsivity of youth and mental illness, these subjects were not able to withstand their perceptions of intense stress. The subjects viewed suicide as the *only* solution to their intolerable pain. The conflicted adolescent subjects made near-fatal suicide attempts alone and with significant ambivalence, and yet, with virtually no communication of the intent to die.

Alienation, or a lack of social integration, was a significant precursor to a near-fatal suicide attempt in this study. Durkheim (1897/1951) characterized social factors as the primary variables in suicide. Societal pressure, the degree an individual felt social bonds or close relationships, correlated highly with the human phenomenon of suicide. Durkheim hypothesized that suicide was positively related to the lack of extent of social integration in family, cultural, religion, and society and sought to ascertain the interconnections (Durkheim, 1897/1951; Hendin, 1987; Trovato, 1992).

Sample Consistency

This study enrolled seven white-non-Hispanic adolescent females who were

determined to have made a near-fatal suicide attempt. This determination was based on the Risk-Rescue Rating Scale results coupled with the study psychiatrist's observations and experience. The adolescents ranged in age from 14 to 17 years, with (3) age 17 years, (2) age 16 years, (1) age 15 years, and (1) age 14 years.

The research protocol for enrolling subjects continued for one year (September 2008 through October 2009). During this period, there were nine near-fatal adolescent suicide attempts admitted to the psychiatric unit, the study site. Two parents refused to allow their adolescent males to participate in the study. The sample comprised 77% of all near-fatal suicide attempts admitted to the psychiatric unit over the 1-year period.

Table 3.

Demographics and Type of Poisoning of the Study Sample

Cases	Age	Sex	Race	Type of Poisoning
Case 1	17y	Female	White	Opiate, NMDA *, NSAID**, Acetaminophen**
Case 2	15y	Female	White	NSAID**
Case 3	17y	Female	White	Antipsychotic, BZP*, AD*, SSRI*, Acetaminophen**
Case 4	17y	Female	White	NSAID**
Case 5	16y	Female	White	Acetaminophen**, BZP, Opiate
Case 6	14y	Female	White	AED**, BZP, Anxiolytic*
Case 7	16y	Female	White	Opiate, Acetaminophen, AED**, Amphetamine, SSRI Atypical Antipsychotic

Note. *AED = anti-epilepsy drug; AD = antidepressant; Anxiolytic = anti-anxiety; BZP = benzodiazepine; NMDA-N = methyl D-aspartate; NSAID = non-steroidal anti-inflammatory drug; SSRI = serotonin reuptake inhibitor. ** = Extreme toxicity

Selection Criteria

The subjects were a purposive sample of seven adolescent females admitted to a suburban area hospital after near-fatal acts of suicide. Upon admission to a nearby children's hospital, the majority of subjects were unresponsive, extremely confused, or unable to care for themselves after severe poisoning. All adolescents required medical stabilization on a pediatric intensive care unit for several days prior to transfer for psychiatric evaluation.

All seven adolescents attempted suicide by self-poisoning with their own or other prescription medications available in the home. There were no guns in any home. Each adolescent expressed her wish to die at the time of the attempt believing that the drugs ingested would lead to death.

There were several serious medical complications in this group due to the self-poisoning. There were numerous medication combinations taken in overdose. The most serious toxicology consequences resulted from three drugs, two of which were over-the-counter (OTC) analgesics. Within the adolescent sample, two ingested the anti-epilepsy drug *valproic acid*; four ingested the OTC drug *acetaminophen*; two ingested the OTC non-steroidal anti-inflammatory drug (NSAID) *naprosyn sodium*. Nationally, OTC medications (specifically acetaminophen and NSAIDs) have been a significant source of morbidity and mortality. Acetaminophen overdose is a leading cause of OTC drug poisoning accounting for more than 80,000 cases yearly. In the U.S., it is the leading cause of drug-induced liver failure (Nourjah, Ahmad, Karwoski, & Willy, 2006). Non-

steroidal anti-inflammatory drug toxicity accounts for thousands of poisonings from unintentional ingestion alone. Toxicity can lead to kidney damage and failure (CDC, 2009a). This drug is not routinely measured in overdoses.

Renal dialysis was considered as an option in two cases due to highly toxic levels of an anti-epilepsy drug (four and five times the therapeutic level) and NSAID toxicity. A liver transplant was suggested as a possible outcome in another case. During their medical hospitalizations, there were concerns for two other adolescents regarding a significant electrocardiogram abnormality (prolonged QT interval) that could have precipitated sudden cardiac death.

During the study, no subject reported any distress, suicidal ideation, or required any extended hospitalization due to study involvement. No subject withdrew from the study.

Psychiatrist's Assessment

The Risk-Rescue Rating Scale for Suicide Attempts was completed for each adolescent to subjectively determine the lethality of the attempt. After informed consents and assents were obtained from each participant, the Risk-Rescue Rating Scale for Suicide Attempts was administered by the study psychiatrist. This type of suicide attempt is significantly more likely to result in death.

Risk-Rescue Rating Scale Results

The results of the Risk-Rescue Rating Scale scoring provided an objective means to verify the subjective reaction to an adolescent's suicide attempt. Table 4 provides the

67

results of the sample's scores. Protocol required that the severity of the attempt be assessed using the Risk-Rescue Rating Scale to differentiate gesture from serious intent (Weisman & Worden, 1972).

In evaluating the risk of completing the suicide, method is a significant determinant. Each adolescent ingested multiple drugs in large quantities. However, drug ingestion has a low potential for lethality in suicide attempts (Shenassa, Catlin, & Buka, 2003), scoring low (one point) in this factor. The toxicity level was considered as another factor. Six adolescents ingested significant amounts of various medications and most developed severe toxicity generating a high score (three points) for 5 out of 7 adolescents. Toxicity is related to level of consciousness. This factor indicates no impairment with a low score (one point) for two adolescents; the adolescents who ingested toxic amounts of drugs scored high (three points) for 5 out of 7 adolescents. Three adolescents were left with the possibility of irreversible damage due to toxicity levels (three points), another with no residual effects (one point), and another with probable permanent damage (three points). All required intensive care unit stays (three points). Higher risk points indicate a more severe attempt.

Rescue factors evaluated discovery. Location of the attempt was familiar (home) for all adolescents; however, several went to bed as usual which indicated that they expected not be disturbed throughout the night (one adolescent was not even noticed as she "stumbled into walls" in the morning).With this consideration in mind, this factor was scored moderate (two points) for six adolescents. The rescuer was known to six out

of seven adolescents (one point). In one instance, a boyfriend, while known to the attempter, came unexpected and uninvited to the home (three points). Likelihood of discovery was uncertain for two adolescents (two points), but considered accidental (three points) in the other five adolescents (one did not tell her parents until the following evening after being very ill much of the day). A large portion of the sample (four) did not ask for help (three points). Two adolescents 'dropped clues' (two points) while one adolescent quickly asked for help (one point). There were significant delays of up to 36 hours until parents learned of the attempt in five adolescents (three points). One participant began to have an allergic reaction (hives) to the ingested codeine causing her to seek help in approximately one hour (two points), according to her records, along with two others who waited between one and four hours (two points). Lower rescue scores indicate less likelihood of discovery. The score is determined when the risk and rescue scores are applied to a severity rating. The highest score is 83 points. The equation is as follows:

risk score/(risk score + rescue score) x 100 = risk-rescue score.

Table 4.

Risk-Rescue Rating Scores of the Study Sample

Case	Age	Risk—Rescue Rating Score
Case 1	17y	66
Case 2	15y	80
Case 3	17y	66
Case 4	17y	66
Case 5	16y	50
Case 6	14y	55
Case 7	16y	66

Note. Score indicates the number of points out of a possible high score of 83 on the Risk—Rescue Rating Scale assessing risk taken versus rescue possibility to a completed suicide. Points ≥ 50 are designated high risk—low rescue.

Data Analysis

The purpose of an inductive data analysis in this case study was to examine the emotions and feelings of the adolescent within the context of the phenomenon of a near-fatal suicide attempt and to ascertain common patterns and consistent themes (Burns & Grove, 2003). The volumes of data generated in this research methodology require filtering to examine possible themes, or patterns. This deconstruction of data in the

content analysis method allows the researcher to examine the framework of the

phenomenon for possible theory building (Miles & Huberman, 1994). The focus of this

case study was on detailing the possible precipitators—mental, physical, and social—of

the suicide attempt to contribute to the knowledge base on adolescent suicide and

prevention. Consideration of the whole person is consistent with the concept of holistic

nursing.

Results of the Data Analysis

   Alienation. Alienation is a multidimensional concept that includes loneliness,

powerlessness, hopelessness, meaninglessness, normlessness, hostility, irrelevancy, an

inflexible way of looking at one's world or solving one's problems (Geyer & Heinz,

1992), ineffective communication, and a perception of loss. Hopelessness has been a

pivotal emotion in the suicidal impulse directly related to suicidal intent (Beck, Rush,

Shaw, & Emery, 1979).These subjects seemed to feel a lack of supportiveness as

expressed in lack of supportive, affectionate communication with their families.

   The results of this study were closely related to Durkheim's (1897/1951)

postulation that the individual who commits suicide was least integrated socially into the

most important relationships in the individual's environment. Family, the basic unit of the

human existence, is the most fundamental of relationships. Despair, as a consequence of

isolation from the family unit, and thus alienation, can become the driving force behind

suicide (Durkheim, 1897/1951). These subjects were alienated from parents and peers.

They lacked healthy egos and coping skills. They were unable to find the emotional

71

support that should have come from the parent. They developed a "sense of inferiority" resulting from a failure to build on previous tasks in life which left these adolescent subjects isolated from even their inner self (Erikson, 1959, p. 124).

Alienation from family and peers prevents 1) adequate expression of the intent to die on the part of the distressed adolescent and 2) adequate interpretation of the child's behaviors on the part of the parent. Social isolation which may influence adolescent psychological health was associated with suicide attempts (Hall-Lande, J., Eisenberg, M., Christenson, S., & Neumark-Sztainer, D., 2007). However, parent-child connectedness is highly protective of suicidal behaviors (Borowsky, Ireland, & Resnick, 2001; CDC, 2009b; Thastum, Johansen, Gubba, Olesen, & Romer, 2008; Winfree & Jiang, 2009, 2010).

Communication. Communication was a powerful issue in this study. Communication has been shown to be a pivotal element in integration of the family, the fundamental unit of society. A system of dysfunctional parent-child interpersonal communication has been demonstrated to prevent the *expression and interpretation* of the adolescent's verbal and non-verbal suicidal design (Dougherty, 2007).

Effective communication has been viewed as a manifestation of healthier family functioning (Jackson, Bijstra, Oostra, & Bosma, 1998). Enhanced communication has been demonstrated to develop family flexibility and adaptability and decrease feelings of estrangement and alienation from the important support groups. Lack of affirmative and supportive parental communication for adolescents contributed to a significantly negative

effect in self-harm when adolescents had an internal locus of control. Self-harm was significant for the adolescent without the family for supportive communication. Significant relationships between self-harm in adolescents and poor communication with parents has been noted (Tulloch, Blizzard, & Pinkus, 1997). It is theorized that a dysfunctional communication system exists between a parent and an adolescent who makes a near-fatal suicide attempt.

Alienation: Estrangement from Parents. Adolescence is a period of starting the task of separation from the parent. Success at this stage is the result of many factors especially emotionally healthy parents who provide a healthy family life throughout the child's lifetime coupled with effective parenting. The subjects in the study perceived estrangement from each parent. This estrangement left the subjects feeling little emotional support and comfort and nominal guidance in tomes of crisis. Some subjects had strayed into drugs such as marijuana, opiates, and benzodiazepines. Additionally, the majority of the subjects reported being sexually active with boyfriends and two subjects reported elective abortions.

Some subjects perceived profound rejection by parents that affected their self-worth. Soon after her drug abuse was discovered, one subject had attempted to start a dialogue with her parent. After a brief conversation with her father, the subject felt she was no longer special to him. She interpreted the conversation as an unsympathetic message, intended or not. She remarked

I just felt that I disappointed them and they really didn't

want to talk to me anymore. They seemed a little distant

after the party…I tried talking to my Dad one night like not

really about anything—just like conversation and it's like

ok, that's just cool. I got hurt because I'm like Daddy's

little girl, and it just really hurt that my parents didn't love

me.

Later, she was asked if she had considered speaking to her mother about her

suicidal feelings as the thoughts were becoming stronger. She indicated her perception

that her parents were unable to have healthy conversational exchanges with the subject

about issues important to the adolescent experience. She stated

No, not at the time. I talked to my friends more about

problems than my parents. I mean, I do live with them, but

I normally don't talk…It's always been that way. We don't

talk about our feelings to each other.

This subject felt a lack of empathy from her parents as well as believing her

parents required so much more of her that she saw herself as inadequate and worthless

because she was not "perfect." She said

Most of the time I'm kind of outgoing and I try to please

my parents. That's what was kind of going through my

head—I'll never be good enough for them or anybody. So I

tried to be perfect. I put myself to standards I know I'll

never stick to.

Many subjects felt that they were unable to even converse with their parents about everyday happenings, a source of bonding between parent and child. This subject expressed a pervasive mindset among adolescents when she remarked

I think one, like talking to my dad is just ridiculous, like

[laughs] cause he thinks he knows everything. Like he

knows, but he doesn't really know me like he still lives in

our house, and he doesn't cheat on my mom, he's a good

dad, I guess. But he's always working, so he doesn't really

know me, but he likes to pretend he does. [laughs] And

talking to my mom, I just don't really, I just don't really try

it that much.

Another subject had been working fulltime after getting a GED. She expressed closeness to her mother, but was concerned about what she perceived as the judgmental attitude of her mother. Since no subject communicated any suicidal threat or intent before their suicide attempt, questions were asked regarding what kept them from sharing thoughts with their parents. When asked about her experience with confiding in her mother, she stated, "I do, but I don't." She was obviously expressing this ambivalence and fear of rejection when she stated

I know she won't not love me because she's my Mom. If I

open myself up too much for my mother, she'll judge me and

not want to be part of my life. She's the only person I trust.

This subject desperately wanted to communicate with her mother when she finally

informed her that she had overdosed on multiple medications. Her mother did not believe

she had overdosed. She reported

I told my Mom I wasn't feeling good. She asks why, and I

told her I took a lot of pills. She said, 'I don't believe you.'

I gave her the bottles, and she saw how much I took…the

valproic acid level was over 200.

The following subject was in the home with her mother upstairs, when her

boyfriend came to the door, unexpected and uninvited. As they talked, she revealed to

him that she had recently overdosed. She stated

… He's the one that actually took me to the hospital… I

told him that I took the pills and then he went to get my

Mom, and he's the one that immediately took me to the

hospital and my Mom followed.

The parent above was in the home at the time of the overdose, but unaware of the

subject's intentions or actions. Due to unknown reasons, the mother did not call 911 in

this emergency and the boyfriend drove the subject to the hospital. This parent is a

master's level trained mental health professional. This same subject expressed her

ambivalence of communicating with her parent about the overdose. She said

76

I think at a point I would have gotten really scared. I wasn't

at the point where I was really scared yet. I was just like

devastated right then, but I think at a point I would have

told my Mom.

This subject's valproic acid level was already 241 by the time she arrived in the emergency room. This was nearly 3 to 4 times higher than a therapeutic level.

In our society, parents are responsible for supporting for a healthy family lifestyle, although the definition of a healthy lifestyle has evolved to fit our changing needs. However, teaching children to problem-solve remains an important task to cope with significant stress. Stress has a significant correlation to suicide and suicidal ideation (Maris, Berman, Silverman, 2000), therefore, learning to problem-solve may ease the pressure of stressful events in the life of an adolescent.

Prior to the near-fatal attempts in this study, all subjects experienced significant stress. This was more stressful as the subjects, it was evident, had not learned complex problem-solving skills. The following subject and the others in this study experienced significant psychosocial stressors. One subject said, "…my Grandpa starts having a heart attack and then I have to worry about him." She also felt an obligation to attend to her Grandfather's health needs as she remarked as might an adult, "The ambulance is there and I see all the lights and start getting dizzy…I made sure my Grandpa is OK first, and then I go inside my house. I'm depressed and everything."

Another subject discussed the death of a young friend who died of an accidental overdose. She had recently attended his funeral. In the recent past, confronting death in a close friend has been uncommon in our society. However, this has become a more common occurrence as the violence-related death rate in adolescents has climbed (CDC, 2008). This subject remarked

> One thing that I think was...that one of my really good
>
> friends passed away…I don't even know why I tried to
>
> overdose on pills because he also overdosed...It was
>
> accidental…It was open casket and everything.

Stress for an adolescent can arise from many issues. This subject has struggled with an eating disorder for many years. She stated, "I've been throwing up a lot for the past year…and it's been really hard and I keep doing it." Her parents had chosen to send her to several out-of-state facilities for treatment of the eating disorder. Her parents have given her the unspoken implication that this is her problem alone and not an issue to be faced with family support. She continued to perceive her body as a distorted image, reflective of her inner self and a source of shame and stress when she stated

> …Someone said something to me like..my chest
>
> looked bigger. And like they meant it as a compliment,
>
> but I was just, 'What do you…' That just means I'm fat.
>
> Cause that's what your chest is, just fat…And that really
>
> got to me.

Impulsivity can contribute to stress. Impulsive actions were, of course, pervasive in this study. It can bring unintended consequences with which some adolescents may be unprepared to cope as they lack the appropriate problem-solving skills. The act of ingesting a substance that they understood could result in their death was impulsive in the majority of subjects in this study. Most subjects admitted to impulsivity. One stated, "I'm very impulsive, and I really didn't have time to think where I was at the time." Another stated, "We went to McDonald's for breakfast and all that and then all of a sudden there was this click." One subject admitted to needing help with her impulsivity saying, "I'm very impulsive when it comes to that, so that what I need to...work on--not being so impulsive." In describing her suicide attempt, this subject succinctly stated, "It was just all of a sudden." Another felt that it was not impulsive and seemed to compare it to a crime when she said, "…so I knew driving home that I was going to take the pills. So, I guess, it was kind of premeditated. It wasn't like I just spontaneously grabbed them."

Another subject was very stressed after blaming herself for her Grandfather's heart attack. She said

> I feel like my Grandpa's heart attack is my fault. So I go
>
> inside and take a whole bottle of [valproic acid] and a
>
> whole bunch of other pills. I'm not sure what kind they
>
> were.

During normal adolescent development, the adolescent is expected to gradually assume adult tasks in preparation for adulthood. In this society, seldom are adolescents

79

expected to perform adult responsibilities, yet it occurs. One subject experienced

significant stress when she assumed adult responsibilities at 16 years of age. She said

> I think it was just everything combined and then like my
>
> work…It's just like I have so much pressure put on me all
>
> the time. I'm the only person in my house that has a job
>
> right now. I have to help with the family. It's just me and
>
> my Mom, but I do what I can to help her. I don't normally
>
> have to do that. I got my GED and work full time…I don't
>
> need to be stressed out…I was just stressed out that day. I
>
> work and, really, at work they put a lot of pressure on me. I
>
> work at McDonald's. It's fast paced. They say I don't do
>
> my work, and I know I do.

All of the subjects in the study were sexually active. One 17-year old subject had had an

elective abortion within the previous three weeks. She had stated in her initial evaluation

that this was not a factor in her suicide attempt stating she "got over it" almost

immediately. She had used drugs for the first time at a party about four days prior to her

overdose. During her drug use, she had passed out due to the quantity. When her

classmates saw her the following week in school, they apparently were commenting

about her behaviors at the party. This was naturally embarrassing for her when "Rumors

started and different things came up." In discussing the incident, she remarked, "I felt like

they thought I was less respectable."

Another subject, 16 years old, also had an elective abortion approximately two years previously. Her suicide attempt was precipitated by an argument with her 18-year old boyfriend about her previous boyfriend. She said, "There was a lot of drama between me and my boyfriend." She felt that perhaps her attempt had been to get his "…attention. To try to get him to notice that it really hurt me…Obviously that was the wrong thing to do and stupid over a guy…" She went on to discuss her thoughts about being involved in a relationship saying

> But now my plan is to not get in a relationship or if I do get
>
> into a relationship, not to get into one very serious. I don't
>
> think right now is the time to do that because I didn't seem
>
> to…respect myself very much and I just wanted to die.

Shame and ambivalence seem to highlight her feelings about herself. She reported little direction from her parents who did not hospitalize her after an overdose three months previously. She is very isolated, remaining at home while attending an online virtual high school. While the subject and her family have resided in the state where the study took place for over three years, the subject continued to see her psychiatrist in a state more than 1,000 miles away.

Another subject, also experiencing relational problems with a boyfriend, reported an argument with him as the precipitating factor. She said her boyfriend was "cheating on me. I found out. He was making out under the bleachers with another girl which started

the whole thing." She did attempt to discuss her hurt feelings with her mother, however, she stated

> When I got home, my mother was acting like a complete
>
> you know what. So I just went upstairs into my room and
>
> got mad. I tried to come out and smooth things over with
>
> her, but she was still upset with me.

Stress, especially over interpersonal relationships and romantic relationships, has been associated with adolescent suicide (Brent et al., 1993). The stress of parent-child discord has also been associated with suicide (Brent et al., 1988).

Parental mental illness including substance abuse is a factor in adolescent suicide (Brent, 1995). This may also contribute to dysfunctional family lifestyle, poor boundaries and ineffective limit-setting by parents, and chaotic personal lifestyles of parents. These disruptive behaviors are significantly associated with suicidal behaviors and suicide (CDC, 2009b; Dougherty, 2007).

Many parents of subjects in this study demonstrated inappropriate parenting skills. For instance, the mother above who was too angry with the subject to allow any discussion to take place. Another subject's mother demonstrated a harsh exterior as the subject related

> I overdosed because my mom told me that she
>
> hated me and she hoped that I died. I felt like it was wrong
>
> because I was selfish…I felt that I should kill myself

because one person told me that they didn't care—the

person that was everything—my mother.

This subject above had experienced the death of her father and, just weeks prior to her overdose, she lost her psychological father when her mother divorced and moved them to another county. The 17-year old subject, after having an elective abortion, was separated from her mother who resided in another city. The subject reported that they had been "best friends" as did another subject speaking of her mother.

One subject reported that she did try to talk with her mother on occasion, however

…whenever I try to talk to my Mom about that kind of stuff

[stress], it's like she starts talking the whole time and she

won't let me say what I want to say. I know she

understands the stress and the pressure. I don't think she

really understands why I wanted to actually commit

suicide. I can't talk to her about that kind of stuff.

One subject's mother was recovering from cocaine dependence. Asked about having a hard time talking to her parent, this subject said

I do, but I don't because my Mom is the only person I have.

I have one other friend…and other than that it's like me

and my Mom. We know stuff about each other, but she

doesn't know everything that goes on in my life, and I

don't know if I'd want to tell her everything. I'm almost

83

like… afraid of her. I know she won't like not love me

because she's my Mom. If I open myself up too much for

my mother, she'll judge me and not want to be part of my

life. I've been through a lot. It was like… she talked behind

my back. She's the only person I do trust. Before when I've

told her, she goes and tells people.

She went on to say

Because I realized it's not just my Mom and stuff that make

me depressed. I have other friends who care about me and

would take me in if I wanted them to so I wouldn't have to

stay with my Mom and be depressed.

This subject stated that her mother was a "perfectionist." She discussed her anger
and, finally, her inability to deal with what she perceived as her mother's pressure for the
subject to be "perfect." She cited this as the reason for her suicide attempt. She remarked

I would say because I have a lot of pressure on me to feel

perfect. I feel not good enough for my parents a lot of

times. They're always telling me that they give me

everything, but they only hold it over my head. Like,

they'll give me a car and a credit card which I am

appreciated for, but then they hold it over my head. Like

'we give you all this and you have this good life, but you

do this.'

This subject was tearful when she related her mother's response to her suicide

attempt. She reported

She didn't believe me until I showed her the pill bottles.

Then she slapped me in the face and told me I was a

'Stupid bitch'…then she called an ambulance…It was a

good thing…I was passed out.

Alienation: Estrangement from Peers. The experience of the developmental stage

of adolescence is a period of identity crisis (Erikson, 1959, 1968). The sub-culture of the

peer group sometimes becomes central in seeking the self and its value. Peer relationships

facilitate this arduous task whether positively or negatively. Many adolescents have not

fully developed their sense of self, leaving them vulnerable to rejection and, literally in

some instances, annihilation from this important entity. The importance of the peer group

is heard in one subject's statement.

I was at a party and got knocked out on drugs…I got to

school Monday and kids who wouldn't even talk to me in

two or three years and people I didn't even know are

coming up to me. I felt very conscious [sic] and told them

to stop bothering me about it…I let too much of it get to

me...People who I thought were my friends were the ones

tearing me down more than anybody else.

This subject related her humiliation and embarrassment in front of her peer group. She felt physically violated by them, saying they were "in my face." She sounded very troubled and her body language was tense and she turned away from the investigator when she said

Like this one kid came up to me…and said I passed out in a

chair. People would come up to me and talk about it. They

would talk to other people about it. They would point and

laugh. Rumors started and different things came up like

what you are saying can't be the truth, but you can't

remember, and they told me it happened. It just all

happened too fast. They wouldn't listen to what I had to say

because of what they'd heard and the fact that I just felt

embarrassed and upset.

It was notable that this subject told the psychiatrist on admission that she had attempted suicide because she was "upset" over her perception that her mother was pressuring her to be "perfect."

Negotiating this crucial stage caused significant stress for the subjects who failed to fully develop an identity separate from the group. The underdeveloped sense of identity left these subjects highly dependent on conformity to peer group expectations.

86

This subject did not wish to return to her small private school where "everyone" knows what occurred (her suicide attempt).

> I think school is stressful, and that puts a lot of pressure on
> people and drama with school I think is pointless. That's
> why I just kind of want to get out of high school and move
> on with my life to do what I want to be. I'd just rather
> move on with my life now than have to stay in high school
> for the next year and a half. I wish I could just skip that and
> then go to college and do what I want in my life so I don't
> have to deal with all the stupid drama and stuff. I think
> that's mostly why. I think I was just tired of life for awhile.

The following subject was diagnosed with an eating disorder. She had been purging and self-mutilating for about two years. Her mother stated she was so obsessed with her weight that she was weighing herself at least ten times per day when her scale had to be removed. The subject, who believed she was fat, weighed 128 pounds and was 5' 7" in height. She stated

> …then so cause I didn't have a scale any more cause my
> mom took it away and I didn't have anything to go by if I
> was gaining weight and then someone said something and I
> finally got it like. And so I didn't want to, I've spent so
> much time worrying about my body like what I look like

and I just didn't want to have a body to deal with anymore.

And if I was dead I wouldn't have to worry about it.

One subject felt rejected by her peers' ridicule after passing out at a party while using drugs. She stated

I felt like I was being picked on more than anyone else. I

felt like people were talking about me whether they were or

not—making jokes, picking on me, left and right.

Lack of Self-Identity. Intimacy is another task in the adolescent developmental stage, closely tied to one's sense of self. Adolescents experience intense emotional attachments to the opposite sex and attach self-worth to being 'loved.' They are unable to establish appropriate intimate relationships until the task of developing a strong self-identity (Erikson, 1959; 1968).

Engaging in young adult sexual behaviors was causing significant problems for these teenage subjects. The majority of these subjects were sexually active, as mentioned above. Two subjects had had an elective abortion, one by the age of 14 years. One subject reported being sexually assaulted four months previously. At least one was treated for a sexually transmitted disease. Most were having significant relational problems with the opposite sex.

This subject felt the stress of an adolescent relationship that had taken on adult dimensions. The 16-year old subject had a detailed explanation regarding her stressful relationships. She remarked

88

Basically what happened is there was a lot of drama
between me and my boyfriend. He went over to my other
ex's house and started ganging up on me or whatever
because he apparently was trying to compare if I said
anything similar to what I said to him to see if I said
anything to my ex that was similar to what I said to him. So
he wanted to see if I was, like, playing him or something.
OK, we've been dating three months and you're just now
trying to figure this out? I was, like, that's sort of weird. So
then [other] girls got involved and he was, like, trying to
make me believe that he did stuff with other girls...It really
hurt me.

Another subject related a fight with her boyfriend the day prior to her attempt.
However, they were "making up" using text messaging and talking over the phone. She
"knew" taking the overdose would "hurt" him.

Another subject discussed her feelings toward her ex-boyfriend when discussing
stress. She said

…Like my ex-boyfriend. He puts stress on me. I still talk to
him all the time. He's the first person I fell in love with. I
don't want to tell him to go away and not talk to me
anymore because I love him so much…Yea, I know I don't

need to be with him because when I was with him, like I

was a lot more depressed. And even though I love him, I

can't do it anymore. I told him that it's so hard.

Lack of Coping Skills. Seeking a "desperate transformation" (Maris, Berman, &

Silverman, 2000, p. 48), subjects perceived their suicide as a solution to their life

problem. Lacking appropriate coping skills, suicide was viewed as the 'only' solution.

('Only' is the four-letter word in suicidology as in the statement, "It was the only thing I

could do!" according to Shneidman [quoted in Maris, Berman, & Silverman, 2000, p.

49]). Coping skills are learned, as most social skills are, in the family. However, a

dysfunctional family has little time for such skills.

The subject diagnosed with an eating disorder continued to say, "And if I was

dead, I wouldn't have to worry about it." Another subject viewed her suicide as

transforming the lives of others when she said, "I thought it would be easier on everyone.

I didn't want to be here anymore."

The 14-year old subject wished to have the validation of her worth she did not see

reflected in her mother's eyes. She stated, "I guess I want her to feel guilty. Like if I did

that, I'd be happy that she felt guilty because it would be her fault. I don't know if she

would feel guilty."

Some subjects saw suicide as a way out of a situation with which they could no

longer cope using their limited adolescent skills.

I told her I just couldn't take it anymore. I was just tired of

everything that was happening. She tried to make me

happier. She said it's not the worst thing. She said it's not

the first time it's ever happened. People always talk about

people. I was listening but not comprehending it.

Other subjects were unable to even relate how their problems began; they just

knew they could no longer cope with the emotions they were feeling at the time. One

stated, "I think I was just tired of life for a while."

Each subject had in common the inability to communicate the intensity of

emotions prior into a near-lethal suicide attempt until the attempt. This focal issue was a

major influence in reaching the point of seeing suicide as the best solution. These

subjects chose silence. This young woman said, "[I can't talk to my Mom.] Basically, she

won't listen." One subject said, "[I felt I couldn't talk to my Mom or Dad because] I just

felt that I disappointed them and they didn't really want to talk to me anymore…It just

really hurt that my parents didn't love me." Another indicated how her depression left her

unable to communicate her needs referring to the initial minutes of her attempt as she

said, "I was thinking this shouldn't be happening. I should tell someone. I was asleep

within a couple minutes." Still another young girl was determined to commit suicide. "[I

didn't tell anyone] because I didn't want anyone to stop me."

There remained a dysfunctional parent-child communication dyad in these subject

suicide attempts (Shemanski-Aldrich & Cerel, 2009). A child who commits suicide-or

91

nearly so-has obviously been in extreme emotional distress. It seems logical that a parent who recognized this state would seek help for their child. However, while multiple factors are recognized in suicide, if communication between a parent and child is flawed, intent to die cannot be adequately expressed or interpreted.

This subject seemed unable to communicate adequately.

> After I took them [pills], I just texted [my boyfriend]: 'I'm
> sorry for all the stupid stuff I do.' Cause I knew after I took
> all the medicine, I knew it was a stupid thing to do. I
> know...I know it hurt him. [He said] 'I'm sorry too. And
> then he was [asking], 'What's going on?' and I was like
> 'Nothing. I just wanted to let you know [that I was sorry].'
> and then I [talked] to him and I just wanted to like, I asked
> him if he 'Could stay on the phone with me till I fall
> asleep? I said that would be nice.' He still doesn't know
> about when…around that phone call. I don't know if he's
> thought about it.

This subject wanted her boyfriend to remain on the phone with her as her life ebbed away. This would have probably traumatized him..

This subject was adamant, even angry, about not communicating when she said

> I don't think [a mental health professional] can say
> anything. If someone said something to me, it wouldn't

92

even matter, like cause it was just me, just what I wanted

and what I had to do…I don't think I would have told [a

mental health professional].

Another subject did not give up easily as she kept everything inside. She seemed almost resigned when she said

[After the OD] I woke up and I was throwing up. And then

I was, then my sister had to get up and go to school and I

was trying to get up to see if I could go and I couldn't. I

was like falling into walls cause I couldn't breathe that well

and then I don't, I just decided I couldn't go, and then I

slept the whole day.

It has been postulated that many suicidal persons have experienced a desire to stop the stream of consciousness of their seemingly unendurable pain (Maris, Berman, & Silverman). The subjects in this study seemed deprived of an inner peace. They had not learned how to cope with complex social issues. These quotes illustrate a profound sense of loss. "I felt like it was the end of the world," and "I don't think anybody really knows [how bad I am hurting.]" "I overdosed because my Mom told me she hated me and she hoped I died." "I didn't want to be here anymore." "It was just me. Just what I wanted and what I had to do." This sense of unease and inability to cope continued long after the recovery from the attempt as exemplified in these statements. This subject added

I really wanted to die. Every time I have tried to kill myself

[before], I took over 100 pills. After I survived this time, I

started feeling suicidal again the other night. I wanted to

take 500. I was choking on the other ones [pills] and didn't

want to throw up. Because that would have been a waste of

my time. That's what I was thinking about at the time.

There was a sense that this act was going to make things easier on everyone else when in

actuality this was their escape. One subject said, "I thought it would [kill me]. I came

very close."

No subject had informed anyone of the intent to suicide prior to the attempt. This

is a common occurrence with minor suicide attempts. Frequently, the adolescent makes

what is commonly referred to as a 'cry for help' in seeking someone to understand their

emotional pain. However, with the fatal and near-fatal attempt, there frequently was no

communication of intent (Handwerk, Larzelere, Friman, & Mitchell, 1998). The subjects

perceived an inability to communicate to a parent the intensity of their wish to die

(Shemanski-Aldrich & Cerel, 2009). However, all subjects expressed ambivalence, the

wish to live and the wish to die (Maris, Berman, & Silverman, 2000). One subject said, "I

wanted to die…But I realized I don't want to die." Another subject did not reveal that she

had taken an overdose, but instead came up with a solution.

She was going to her friend's house, and I said "I'm going

to go with you." If I hadn't decided to go with her, I

wouldn't be here right now because I wouldn't have called

911. I would have gone to sleep and never woke up again.

Despite all expressing happiness about surviving their attempt, these young girls continued to remain apart from the world while still in it. Each imagined being estranged from life and their own lives and from the lives of their parents and peers. Each was still unable to ask for emotional support. These subjects were filled with ambivalence about not succeeding in taking their own lives. Research on this aspect of suicidal ideation has demonstrated that high severity of suicidal intent was strongly and positively correlated to the wish to die versus the wish to live (Brown, Steer, Henriques, Beck, 2005; Kovacs & Beck, 1977).

This subject, who had been depressed over the accidental overdose death of her friend the previous week, had attended his funeral just prior to her own attempt. She was expressing significant ambivalence when she said, "It didn't tell me that I don't need to be putting pills in my mouth."

Another subject remarked about her thoughts after just having ingested pills to commit suicide.

I took the Robitussin to fall asleep so I didn't have time to

think about it in case my conscience did catch up with me. I

was thinking this shouldn't be happening. I should tell

someone. I was asleep within a couple minutes.

There was a loss of connection with others in their lives. All believed in the finality of the journey they were about to begin. Another subject expressed these ambivalent feelings when she said

> When I took all the pills, I think I had both thoughts in my
> head—I wanted to die, but I didn't want to die. The only
> reason I probably wanted to die, or more to just go to sleep
> for awhile, maybe go to sleep for two weeks and then wake
> up and just go back to my life. More, I just wanted a
> break…

This young woman took one of the more serious overdoses. She was expressing significant ambivalence even as she nearly died when she remarked

> I took the medicine on …Sunday night. I even packed all
> my bags and stuff to go to school tomorrow, I took a
> shower, and fixed my hair, just in case I woke up…

The majority of these subjects believed that the pills they ingested were going to kill them and did not expect rescue. None of these subjects communicated in any manner the intent to commit suicide prior to the actual attempt. Yet, all expressed ambivalence about dying and still went through with it.

Model of Path of Near-Fatal Adolescent Suicide Attempt

The path of a near-fatal suicide attempt has its origins in the family. Social integration, long known to have a significant correlation with suicide (Durkheim,

1987/1951), was a key factor in the near-fatal suicide attempt in this sample of adolescent females. Communication exchange has been stifled for a multitude of reasons and adolescents have not demonstrated adequate coping skills. These subjects were stressed and overwhelmed, unable to turn to parents or peers for catharsis through socialization.

Based on the study subjects' experiences, the path of an adolescent near-fatal suicide attempt was proposed to stem from social integration issues (refer to Model of the Path of Near-Fatal Adolescent Suicide Attempt, Figure 1). The adolescent subject had become alienated from two major social support groups—parents and peers. These social groups help the adolescent to develop a sense of self, or self-identity. Alienation from these groups left the adolescent vulnerable to assaults due, in part, to an existing under-developed self-identity. Alone and distressed, the adolescent was left to cope, but without demonstrating appropriate coping skills.

Retreating further into isolation , despair, and hopelessness, the adolescent became convinced of a personal lack of worth. The adolescent no longer sought support from either group. Yet, the subjects, perceiving rejection and ridicule, only suffered more distress. Eventually, suicide was felt to be the *only* solution to re-establish balance. While still struggling between the wish to die and the wish to live, these subjects quietly attempted suicide to end the intolerable pain.

Throughout this study, the critical lack of proficient communication skills was evident between the subjects and the two major social support groups. The parental issues of unsuccessful parenting skills led directly to a significant problem in parent-child

97

communication. The subjects perceived a lack of empathy in parental communications, both verbal and non-verbal, thus signaling the perception of lack of support and understanding.

A child's coping skills closely paralleled the degree of parental supportive communication and parental coping skills evidenced in this and other research (Thastum, Johansen, Gubba, Olesen, & Romer, 2008). For a multitude of reasons, the parent with a lack of proficiency in this area cannot teach their own child the necessary skills for supportive communication (Burleson, 2009). This lack of supportive communication contributed to subject distress, increased isolation and, eventual estrangement from the parent figures.

The peer group is a vital part of adolescence. Peer issues contributed to the subjects' perceived lack of this social support through rejection and ridicule by peers. Effective parent-child communication mitigated negative peer influences (Winfree & Jiang, 2009). However, the subjects did not possess the learned skills in communication to cope with the experience in a more rational manner. Without this important social support from peers, the subjects did not experience a crucial reduction in distress (Burleson, 2009). On the contrary, subjects withdrew from peers to avoid additional anxiety and emotional pain. This contributed to further isolation and estrangement from the peer group. Struggles against perceptions of high degrees of social integration and external control are hallmarks of the adolescent developmental stage (Erikson, 1959, 1968).

The family and peer group are significant resources in the adolescent's development of self-identity. The learned values of the family are important tools for the adolescent struggling with autonomy while the peer group is the standard of individuation. Thus, the main task of adolescence is the balancing of these parental and peer expectations based on the learned family values. This is a crucial step in determining one's own identity while progressing to autonomy (Erickson, 1959, 1968). The adolescent learns skills to individuate that emanate to a measurable degree from parenting.

The adolescent who perceives rejection by both important groups, parents and peers, is without social support. The isolated adolescent, now feeling vulnerable and powerless without a sense of identity, is alienated from these support groups. These adolescents have no connectedness to family or society. Durkheim (1897/1951) described this condition as a lack of social integration. He reflected that "excessive individualism" (p. 210) resulted when a person's bonds to their own *society* (re: family and peers) became detached. The loosening of the bonds of social integration and eventual alienation from important support groups resulted in (egoistic) suicide (Durkheim, 1897/1951).

Alienation from these major social support groups leaves the adolescent unable to cope with these estrangements. Ineffective parenting had the consequence of ineffectual limits for these subjects resulting in stressful activities (such as early sexual encounters, unwanted pregnancies, drug use, and school failures) for which they were ill-equipped to

99

deal. Thus, the subjects were without rational, adaptive coping skills and suffering with the perception, or reality, of inadequate social support. Coupled with the impulsivity of youth and mental illness, these subjects were not able to withstand the perception of extreme stress in the face of alienation from parents and peers.

The resultant near-fatal suicide attempts of these subjects were initiated with great ambivalence and yet none communicated intent before attempting the suicide. The lack of communication spoke, for many, to the perception (or desire) that death would occur.

The results that emanated from this research are depicted in the Model of the Path of Near-Fatal Adolescent Suicide Attempt (see Figure 1). This model illustrates the sub-concepts impact on the major concepts of Estrangement from Parents and Estrangement from Peers. Both social groups influence socialization and, thus, Self-Identity in youth. These organizing concepts significantly effect the youth in dealing with stressors. Without support from major social groups, the adolescent became isolated and alienated. Without attachments, youth have not developed an effective sense of Self-Identity. The adolescent thus becomes vulnerable to internal and external stressors. Alienation has prevented the learning, assimilation, and adaptation of coping skills to deal with unfamiliar stress. Without coping skills, the adolescent leaps to the conclusion that suicide is the *only* solution to the stress and leads directly to the near-fatal suicide attempt in this sample.

Peer Rejection

Peer Ridicule

Communication

PARENTING ISSUES

PEER ISSUES

LACK OF SELF-IDENTITY

ESTRANGEMENT FROM PARENTS

ESTRANGEMENT FROM PEERS

ALIENATION

Stress

No Self-Limits

Impulsivity

Communication Issues

LACK OF COPING SKILLS

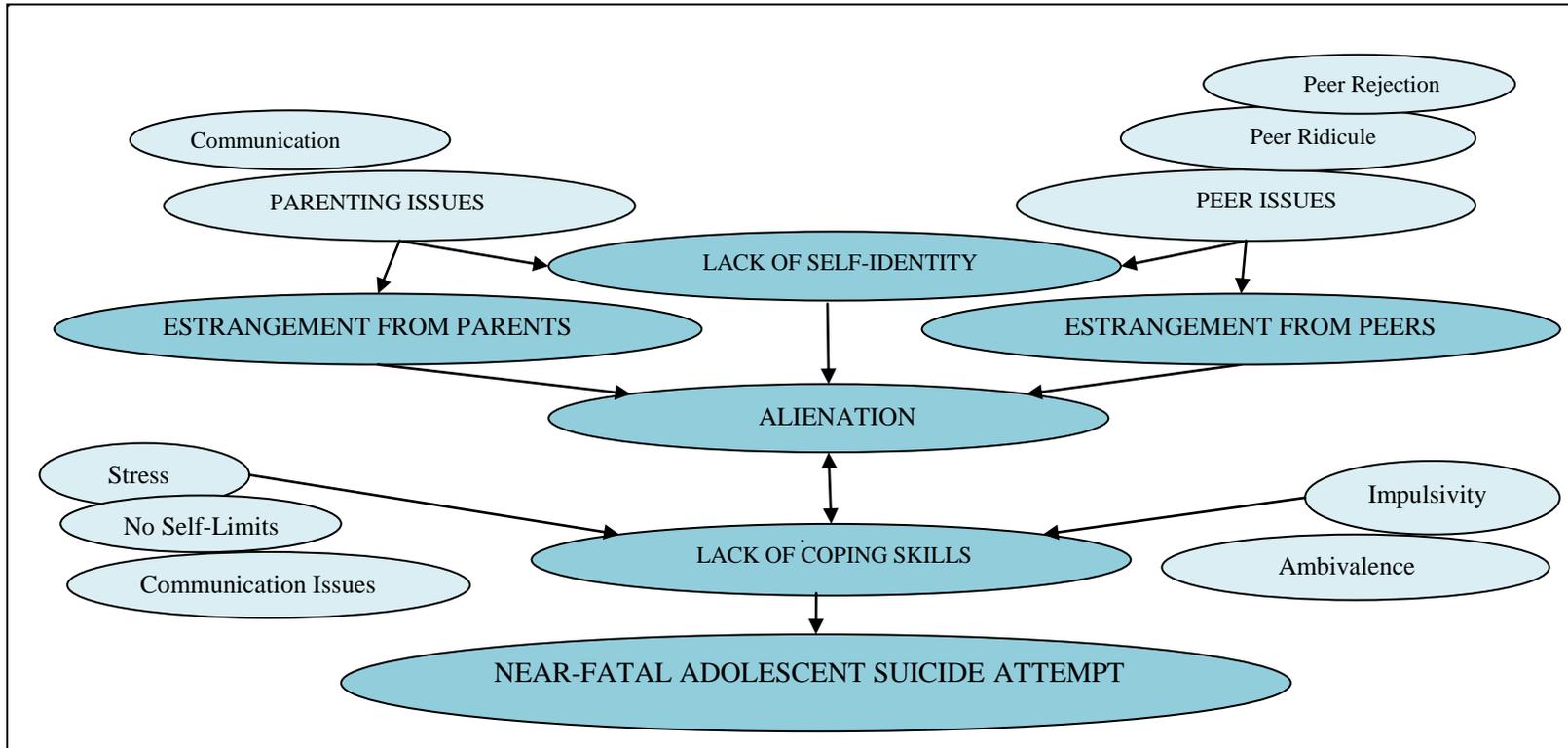Ambivalence

NEAR-FATAL ADOLESCENT SUICIDE ATTEMPT

Figure 1. Model of the Path of Near-Fatal Adolescent Suicide Attempt. Estranged from the important social groups of parents and peers and lacking self-identity, subjects became alienated from needed social support. Without adaptive coping skills, a near-fatal suicide attempt resulted. This is a non-causal model.

Summary

Qualitative research explores true expressions of lives through the observation and immersion in the life before us. The intent of the qualitative study is a pursuit for the patterns, meanings, and values gathered from fragments of the subject's stream of consciousness. The subjects in this study articulated a collective representation from the individual experiences of a near-fatal suicide attempt. This study endeavored to delineate the similarities in these near-fatal suicide attempts.

Results from the subjects' case analyses were presented in this chapter. The focal categories obtained through the inductive method of qualitative research were identified. These results indicated three broad categories. These categories were estrangement from parents and peers, lack of coping skills, and lack of sense of self. This subsumes into the concept of alienation from society. These results were closely aligned with the sociological concept of alienation, or lack of social integration with society that Durkheim (1897/1951) first postulated in the classic *Le Suicide*. Sample consistency and results of the selection criteria were detailed. The study psychiatrist's experience and observation and use of the Risk-Rescue Rating Scale to evaluate lethality of the suicide attempts was reviewed. The qualitative standards for critiquing the research were presented.

Chapter V

Discussions, Implications, Recommendations, Conclusions

A discussion of the research findings is presented in this final chapter. Specific aims, strengths, and limitations of the study are addressed. Implications for the discipline of nursing and nursing research with recommendations for future research are reviewed.

Suicide has become a leading cause of death in the U.S. adolescent population and the trend is not abating. The Surgeon General's *Call to Action* (CDC, 2001a) highlighted this issue and the urgency in determining viable options in the prevention and treatment of this tragic loss of young life and the emotional and economic havoc accompanying it. Suicidologists are examining new foundations in suicide research to address the issue. One of the prevention methodologies addressed in the nation's current strategy for reducing suicide (CDC, 2001) is to advance the science of prevention including enhanced understanding of the risk and protective factors in youth suicide. The CDC has broadened its research agenda in suicide prevention with significant attention to new venues that have not been sufficiently addressed in the literature. One of these venues is a new focus on research of the near-lethal suicide attempt. The prevailing paradigm in suicidology has been to reconstruct the lives of the victims of completed suicide by interviewing friends and families of victims by seeking clarity through diagnoses and statistics. While this has been informative and instructive in many respects, the suicide trends continue with little abatement. A new paradigm in suicidology research has reached a consensus (Conner, Duberstein, Conwell, Seidlitz, & Caine, 2001;

Hammond, 2001; Potter et al., 2001; Powell et al., 2001; WHO, 2002). The new strategy

for suicide prevention has become the study of the "near miss" (O'Carroll, Crosby,

Mercy, Lee, & Simon, 2001, p. 3), or the nearly lethal suicide attempt. The psychological

autopsy method is subject to recall biases and the lack of sufficient motivation of the

parents of the control subjects in the study when compared to suicide victims' parents

which then calls into question the quality and validity of the information obtained

(O'Carroll et al., 2001). As a relatively new approach to suicide research, the

phenomenon of the adolescent near-fatal suicide attempt has not been well documented in

the current body of literature.

Specific Aims

The results of specific aims of this study in regards to educating a new nursing

scientist are addressed.

Aim 1. Promote nursing science theory in the practice of prediction and

prevention of adolescent suicide through the qualitative investigation of the lived

experience of adolescent near-fatal suicide attempts. There is little research done on the

acute psychiatric unit (Roach, Duxbury, Wright, Bradley, & Harris, 2009) and significant

barriers remain to be crossed. However, this study demonstrated that those barriers to

nursing research can be overcome. Specifically, in the research of the suicidal adolescent,

it is imperative that the discipline of nursing persist in gaining access. No advances can

be made toward theory or prevention without the research. This study further

demonstrated that the qualitative method can contribute to the understanding of these

adolescent suicide attempts. Data that were obtained were poignantly rich narratives.

The inductive process of distilling this data enhances the definition of the near-fatal suicide attempt. This contributes to the development of our understanding of the processes involved in this phenomenon, not only in nursing, but also in the multidisciplinary field of suicidology. Ultimately, through enhancement of the definition of the phenomenon of interest, this study is contributing to theory development in suicide research. With understanding of adolescent suicide risks and protective factors comes the ability to design prevention interventions.

Aim 2. Provide alternative research data through the qualitative study of near-fatal suicide attempts to contribute to adolescent suicide prediction and prevention efforts. According to major suicidologists (Maris, Berman, & Silverman, 2000), one of the undeniable facts in suicide research is the inability to interview the completed suicide victim. Suicide survivors account for the overwhelming majority of suicide attempts, significantly out-numbering completed suicides. Thus many conclusions in suicidology are based on survivors (Dougherty, 2007). However, the vast majority of adolescent suicide survivors have made attempts that are not considered serious enough to warrant treatment (CDC, 2008). Due to significant differences in the characteristics of the victims of completed suicide versus suicide attempts, the new direction in research is to access the experiences of the near-fatal attempts. There are, however, few such attempts to study (CDC, 2008; Hawton, 2001). Therefore, this study has made significant contributions to the science of suicidology in designing and implementing research of near-fatal suicide subjects and in identifying and interviewing these severely suicidal adolescents in a safe

environment. The successful conclusion to the study provides the opportunity for other nurse scientists to make similar contributions to suicidologyand the discipline of nursing.

Aim 3. Provide data to examine the emerging patterns in the adolescent near-fatal suicide attempt based on qualitative data coding obtained through the lived experiences of those adolescents. The data obtained were poignant and rich. The valuable narratives recorded verbatim provided immense volumes of data for cultivation. This considerably enhanced the content analysis process and its outcomes. The audit trail can provide other researchers with data to replicate the study.

Aim 4. Express the inherent value of the perceptions, thoughts, and feelings of adolescent near-fatal suicide attempters by focusing on the qualitatively-obtained descriptive experience. There is a paucity of research into the adolescent near-fatal suicide attempt. The narratives obtained seemed to express true feelings and perceptions contributing to the credibility of the research. The veracity of this contribution enabled the researcher to focus on the strength of the content and present findings with confidence that the present study has inherent dynamic character to engage the reader.

Strengths of the Research

Credibility. Credibility is a significant criterion for influential qualitative research. Objective examination of the strengths and weaknesses of the qualitative study contribute to this end (Burns & Grove, 2003). The case study has gained significant credibility as a research method in the discipline of nursing (McGloin, 2008). It has specifically expanded the heuristic value of a phenomenon of interest to the discipline by enhancing the reader's understanding and appreciation of the experience through its richness of

description (Merriam, 1998). This methodology is well suited to nursing's holistic approach to the experience of dis-ease since nursing has embraced the source of dis-ease as inseparable from the human condition. The qualitative investigator has been cautioned to maintain integrity to alleviate concerns about bias in producing results that the investigator wanted or expected to reveal (Thorne, 1997). In studying this phenomenon of the near-fatal suicide attempt, this investigator had no preconceived notions of what to expect. These candid conversations were just as revealing to the investigator as to the reader. Prolonged contact with the subjects ensured significant amounts of data that helped to substantiate the adolescent suicide experience. Themes were thoroughly evaluated for congruence to check credibility, including with an outside qualitative investigator.

Audiotaping was another method of ensuring the subject's true emotions were freely expressed. This method of interviewing avoided inadvertently suggesting any importance or relevance of an answer that may be implied by writing something down on paper, thus distorting the narrative. Audiotaping had the added benefit of allowing the investigator to remain focused on answers and on non-verbal cues. Field notes were also jotted down post-interview.

Dependability. This study utilized parts of a conversational interview technique and the psychiatric interview. It was hoped that this method would not place undue pressure on the informants, but guide them to essential parts of their account. Already, these adolescents were prepared to explore a very dark and sad place in their hearts where, most likely, they had not yet ventured. It was therefore imperative to develop and

107

sustain trust throughout the interview.

These audio-recordings of the interviews provided a verbatim account of each interview. This method ensured an accurate and dependable narration of the subject's individual experience. This also allowed for consensual validation by the outside qualitative investigator. The study investigator did not have to depend on memory or imprecise note keeping of such intense memories and expressions.

Dependability through consensual validation was undertaken by an outside qualitative investigator reviewing the paperwork of the analysis. This *audit trail* consisted of the tape recordings and their transcripts, transcription coding, notes in margins of interviews, field notes, and other investigator-generated work. This study also included necessary medical histories, psychiatric evaluations, test results, and the risk-rescue assessment rating work-ups. This paperwork, in turn, can be used by future qualitative investigators to evaluate the quality of the analysis by following the *trail* of paperwork.

Transferability. Transferability, or generalizability, is not an imperative issue in the case study. While exploring the phenomenon in other groups may find similarities, these remain for future work. However, the participants' emotions and expressions of those emotions showed congruence within this study.

Saturation was evident early in the data collection phase. Saturation in qualitative research is the point at which no new information or themes are observed during data collection. It has been used traditionally to determine sample size. Frequently, an investigator will cease data collection at such a point. However, as Morse (1989) observes, continued data collection may give rise to new perspectives. This study was

continued for one year in the hope of capturing as many subjects as possible. The study

was continued until the last possible moment to ensure recruitment of as many subjects as

available. The subjects, found to be highly motivated to discuss their lived experience,

made this a worthwhile endeavor. It provided rich, trustworthy data for analysis of the

research.

Role of the Investigator

The investigator has a crucial responsibility to be well-trained, fair-minded, and

empathetic and responsive to minimize possible distortions to the work through diligent

self-monitoring. The investigator remained professional and avoided personal

involvement. An empathetically neutral and impartial position while maintaining a caring

and responsive demeanor was maintained as imperative for trustworthiness, credibility,

and dependability of outcomes.

Limitations of the Research

Restricted Sample Size. The small sample size in this study is, in part, a reflection

of the small number of near-fatal suicides reported in the nation. There are no statistics on

near-fatal suicide attempts seen in U.S. hospitals (CDC, 2009c). The only large scale

study of this kind was conducted in a metropolitan city with a population of over 4

million. During they study, only 43 near-fatal adolescent suicides, ages 13 to 19 years,

were recruited (Kresnow et al., 2001; Powell et al., 2001).

Additionally, the current study was limited by an all female sample. This lack of

diversity is most likely due to the low lethality of poisoning, the method of suicide

chosen by a majority of adolescent females. Poisoning is considered to be significantly

less lethal than firearms, the method chosen by a majority of males in this age group. More than 90% of those who chose firearms completed the suicide (American Academy of Pediatrics, 2000; CDC, 2010; Sadock et al., 2000; Weisman & Worden, 1972) and, thus, account for fewer admissions.

In 2006, the most current year for which statistics on suicide are published, there were 216 suicides in the 10 to 14 year age group and 1,555 suicides in the 15 to 19 year age group, all races and both sexes. However, there were 31,518 suicides in the 20 to 85+ age group during the same period. This represented 0.01% of the total U.S. population (2006: 301.2 million), making suicide in this age group the 11th leading cause of death. The total adolescent suicides represented less than 0.0005% of the total U.S. population, but 0.0035% of the total adolescent population (2006: 42.1 million) and the 3rd leading cause of death (CDC, 2009c; U.S. Census Bureau, 2009).

The largest U.S. study of near-fatal suicide attempts was conducted in Houston, Texas (Kresnow et al., 2001). Between 1992 through 1995, a 32-month period, there were 143 near-fatal suicide attempts examined in the quantitative study. There were 43 adolescents ages 13 to 19 years in the study. Houston, one of the largest cities in the United States, had a population of greater than 4.1 million compared to the population of the study's cachement area, which consisted of less than 100,000 persons (U.S. Census Bureau, 2009). However, the study cachement area had the highest suicide rate in the country at one time with an increase of 130% between 1980 and 1986 (National Center for Health Statistics, 1987). The Houston study did not delineate any study information regarding attributes other than age. The Houston study did not provide data on the

adolescents other than their demographics and age of onset of alcohol use (Kresnow et al., 2001; Powell et al., 2001).

In the current study, the lack of diversity in the race and ethnicity of the sample was, in part, an artifact of the location of the study site and surrounding area. It may also be attributed to the low numbers of suicides (and thus—theoretically—suicide attempts) of female adolescents of color. Between 2003 and 2006, the incidence rate for African American female adolescents, ages 10 to 14 years, was 0.6/100,000 adolescents and for ages 15 to 19 years, was 1.4/100,000 adolescents. However, the rate for white female adolescents, ages 15 to 19 years was 3.0/100,000 adolescents. Statistically, the likelihood of a white female suicide attempter to be an admission is greater, possibly accounting for the study sample.

Limitations of the Method. There are limitations to all methodological inquiry. While the case study method may not determine a universal principle that applies to all cases, few research efforts make such inroads into a phenomenon. However, the case study can contribute to significant theory-building for the discipline of nursing. The quantitative approach has defined the scientific method of research as originating from observable, empirical, and measurable data. These data are subject to confirmation through experimentation and, ultimately, generalizable to applicable areas.

The case study method can be thought of as limiting in the unbounded and seemingly uncontrolled environment in which it takes place. This gives the impression of a lack of usefulness as an indicator of *cause and effect* since variables are uncontrolled. It is a complex task to develop *correlations* among values in the qualitative inquiry. In this

111

aspect of inferences and conclusions, it is unlike the quantitative method that asserts the *statistical significance* in order to proffer generalizations.

The qualitative study does not construct statistical models from numerical data. Data are generated for qualitative research with such inexact tools as interviews, observations, pictures, oral accounts, and storytelling among others. This type of data are challenging, if not impossible, to quantify. In the quantitative study, the hypothesis generates the experiment through the objective precision of statistics. However, the inferences and theory in qualitative study emerge from the data. Considered ungrounded by quantitative investigators, qualitative interpretations have been labeled as subjective, flexible, reflexive, and open to interpretation (McGloin, 2008; Ryan-Nicholls & Will, 2009).

Methodological rigor has been cited as a stumbling block in qualitative research (McGloin, 2008; Ryan-Nicholls & Will, 2009). It is not possible to quantify the immersion in the data that accompanies this research. This holistic immersion in the research and its interpretation are not measurable for credibility. In determining credibility, the reader must rely on the investigator's qualifications for the adequateness of interpretation and the agreement of others with the descriptive findings. Much of the dependability is based not on objectification of data collection instruments, but on the investigator who is, in essence, the *instrument*.

Admittedly, critique of the qualitative method is as evolving as the method itself (Mitchell, 2004; Morse, 1997). It is a highly subjective method of discovery that for some has been and still is like an art form and just as problematic to interpret (Mitchell, 2004;

112

Parse, 1985). However, this experiential approach to analyzing a phenomenon that may not generalize to similar phenomena has left some with consternation about the methodology. Validity has become an important benchmark in nursing research for evidenced-based practice (Burns & Grove, 2003) perceived by some to be lacking in the qualitative method.

As basic research, application of the results of this study to other settings has yet to be developed. However, the findings may contribute to an increased awareness and sensitivity to the impact of adolescent suicide and suicide attempts on those experiencing this phenomenon. The themes of Estrangement from Parents and Estrangement from Peers may reveal areas to target treatment of adolescents at risk for suicide.

Restricted Sample Size. The number of subjects in this study sample was small. It represented 77% of all near-fatal adolescent suicides admitted to the adolescent psychiatric unit in the period of one year. The number of adolescents in the sample is consistent with national figures that revealed the number of adolescents who committed suicide in one year in the entire country in 2006.

This statistic may seem small as suicide is listed as a leading cause of death in adolescents, ages 15 to 18 years. Death in adolescence occurred primarily from unintentional injury (4,776 deaths) and homicide (1,582 deaths) (CDC, 2009a). These deaths represent nearly 17% of adolescent deaths in the same period. During this study, the majority of suicide attempts admitted to the unit (greater than 400) were calls for help and did not meet the criteria for a near-fatal suicide attempt.

The recorded interview provided an opportunity for each subject to re-experience the emotions of their near-fatal suicide attempt. This allowed the subject to reveal deep-seated emotions and conditions that lead to the attempt and begin the process of emotional catharsis with an experienced therapist.

Analysis of the data using Burnard's (1991) stages for rigorous content analysis revealed three focal issues common to all subjects. The themes of Estrangement from Parents and Peers, Lack of Self-Identity, and Lack of Coping Skills leading to Alienation were present in each subject's interview of the near-fatal suicide experience. It was apparent that the retelling of these experiences provided a therapeutic medium to assist these subjects in beginning the work of exploring their intense emotions. It became evident that providing an opportunity for group therapy in a protected environment in which the subjects could discuss and work through hidden feelings, both conscious and unconscious, would be required. It indicated that the short-term hospitalization prevalent in today's atmosphere of managed care would, in all probability, not be sufficient for this process.

The data from this study lends weight that family therapy may support the subjects and parents in learning communication skills. Supportive communication is a pivotal necessity in the closely integrated family. Enhancing communication skills between the subjects and parents may provide a foundation on which to rebuild the strongest emotional bond in the subjects' lives. It could help family members recognize the importance of reestablishing support with the subject.

Implications for Nursing

Implications from the study identified the need for improved preventative measures in a number of areas. Suicide will continue to be a leading cause of death in adolescents until the initiation of enhanced prevention methods. Nursing, with direct access to suicidal and potentially suicidal patients, can be influential in these areas.

Understanding that the path of adolescent near-fatal suicide attempts in this current study emanated from alienation from the two major social support groups in the adolescent's life—parents and peers—and a failure to develop self-identity, the A.R.N.P. and psychiatric nurse educator can develop an awareness for this potential in clients and parents. During the psychotropic medication management session as well as individual and family therapies, the A.R.N.P. always assesses for the potential for suicide in a client. Knowledge of this path model could prompt an additional assessment of the degree of estrangement/alienation from the parents and family. Providing professional support outside the parent/peer groups could ground the client in reality until effective communication skills can be nurtured in the adolescent and family. This study demonstrated that parent and peer support was instrumental in the lives of these adolescent females. This understanding could prompt evaluation for treatment to elicit therapeutic parent/adolescent communication with potentially unstable adolescent females.

Following suggestions in the National Strategy on Suicide Prevention (CDC, 2001b), research on suicide including designing and completing studies should be promoted in nursing colleges. Faculty need to assist students in designing safety

protocols such as the ones in this study for research into adolescent suicide and in

negotiating the Institutional Review Board process for approval of these studies. They

should also educate board members to be more cognizant of the need for research in this

field.

Recommendations for Future Research

The Surgeon General's *Call to Action* (CDC, 2001a) highlighted the need for

innovation in youth suicide prevention. The National Institute of Mental Health (NIMH)

has placed a high priority on means to increase prevention and intervention research

efforts into youth suicide. This study and its findings in near-fatal adolescent suicide

suggest many avenues for future research within the discipline of nursing.

Replicating this study utilizing multiple hospital sites and extending the time for

recruiting subjects would likely result in a significantly larger and more diverse sample of

adolescents with enhanced implications for generalizations. Future investigators should

strive to include publically funded hospitals as study sites to capture data from uninsured

subjects that could add more dimension to a study. A study designed to contrast data

obtained from a group of adolescent subjects who have made minor suicidal gestures

with those making near-fatal attempts may present opportunities for future research

efforts to examine the results of alienation, lack of coping skills, and lack of self-identity

as consistent findings between groups.

During the one-year study period only two adolescent males met criteria for a

near-fatal attempt contrasted with seven females who met criteria. This may be an

indicator that due to lethality of method males are less likely to survive and thus unlikely

to be included in such studies. However, a future study designed to examine gender differences in near-fatal suicides may provide an adequate number of male subjects if a longer time period or multiple sites are designated.

A study incorporating the out-patient setting with follow-up interviews after discharge may provide indications for reliability over time. However, institutions are reluctant to engage in research with such perceived liability as adolescent suicide without significant safeguards. Based on the significant difficulties encountered in gaining permission for the current study, the design of a future study of adolescent suicide outside the protective resources of the hospital would, most likely, need to include similar pre- and post-interviews with a psychiatrist to obtain IRB sanction. Engaging these follow-up interviews in the same offices as the psychiatrist would be important as well as advantageous for all parties. Arranging study interviews for the same days as medication management sessions with the psychiatrist would have the added benefit of prolonged assessment with a parent present. The addition of these precautions to any future study with follow-up interviews after discharge would be more likely to satisfy IRB human subject safety concerns and gain prompt approval.

The findings of this study have relevance for future endeavors to address the research and development of an awareness program for out-patient providers. Awareness of the adolescent's alienation from family and friends, lack of coping skills, and lack of self-identity could trigger the provider's intervention in any possible suicidal ideation, intent or plan by the adolescent. Future research into development of such an awareness intervention could significantly enhance suicide prevention efforts. Engaging the parents

117

of subjects in concurrent interviews may provide insights into parent-centered behaviors, emotions, and needs related to the attempt. The study results contribute to the body of knowledge of adolescent suicidal behavior for furthering research into the design of an instrument to identify potential serious suicide attempts.

Every investigator can most likely envision suggestions to improve the technical aspect of the qualitative research study. Due to small sample size, the interviews in this study were recorded on a microcassette, then transcribed by a certified medical transcriptionist meeting HIPPA requirements, but involved considerable cost. Future studies could limit costs with larger sample sizes by using newer digital techniques. Future qualitative investigators would benefit from recording with digital equipment such as the MP3 player which is also a flash drive connecting directly to the computer. Several software programs have been designed to transcribe the spoken word, saving significant time and energy and cost in transcription for the investigator. Data analysis time with larger samples can be shortened using a qualitative research software package like Nudist or Atlas.ti to determine thematic content rather than the Burnard method, done by hand.

Conclusions

This research into the lived experience of the adolescent near-fatal suicide attempt serves as a poignant reminder that suicide remains the 3rd leading cause of death in American adolescents. There are many factors along this path that contributed to the attempt. A child who commits—or nearly commits—suicide has obviously been in extreme emotional distress. It seems logical that a parent who recognizes this state would seek help for their child. While multiple factors are recognized as important in adolescent

suicide, alienation of the adolescent from parents and peers interferes with the necessary

communication to adequately express or interpret the intent to die. Other studies have

demonstrated that adolescents who completed suicide experienced *significantly less*

frequent and supportive communication with parents compared to adolescents who only

attempted suicide. This may indicate a line of communication was open between parents

and suicide attempters, but not the adolescents who completed suicide (Brent et al., 1988;

Gould et al.,1996). This may actually be an indicator of more, albeit dysfunctional,

communication between parent and the adolescent who only attempts and an indicator of

more integration into the family unit than previously believed since communication can

occur on diverse levels such as verbal, written, and behavioral. Isolation was

hypothesized to result from highly significant poor parent-child communication exchange

(Miller, King, Shain, & Naylor, 1992).

   Additionally, adolescents have reported lower levels of cohesion in the family.

When loneliness is defined as emotional distress due to feelings of estrangement,

loneliness in adolescents can be a function of the lack of social integration in a family.

Lack of social integration has been measured in parent-child communication (Brage,

1993). Sullivan (1953) stated that psychopathology was crucially linked with loneliness

in human behavior. Loneliness correlated significantly with depression, self-esteem, and

significantly negatively correlated to family strengths and mother-adolescent

communication (Brage, 1993). Age was a factor in that those adolescents in the age group

15-19 years were lonelier than younger adolescents, a function of the developmental

stage (Piaget, 1952). This is a factor that coincides with the higher rates of suicide in that

age group.

With an external locus of control in problem-solving, families were equated with more under-organization, emotional distancing, and neglectful parenting. This directly affected problem-solving ability. Families of this type demonstrated little communication and avoidance of eye and physical contact. Families with an authoritarian locus of control were characterized by rigid parenting, expectation of conformity, and dictation of terms by the parent in charge. Communication was task-oriented. The families demonstrating individualistic locus of control experienced the most hostility, self-centered problem-solving, and coercion. Communication was centered around a self-serving solution. Locus of control has been established as a personality component through which children learn to manipulate --and communicate-- with their world. Rigid family functioning has been demonstrated to be a significant negative factor in suicidal ideation in late adolescence (Carris, Sheeber, & Howe, 1998).

Further miscommunication of parents and their adolescents has been shown in a comparison of parental awareness of their child's risk behaviors. Parents were unaware that their child smoked marijuana (child said yes:22% vs. parent said no: 98%) or cigarettes (43% vs. 76%), consumed alcohol (49% vs. 85%), or engaged in sexual activity (33% vs. 92%). Parents did not know that their child carried a weapon to school (22% vs. 89%) or used LSD and/or cocaine (8% vs. 98%). Perhaps most significantly, 22% of teens reported suicide attempts, however, 98% of parents reported that their teen had never attempted suicide. These behaviors were 3 to 29 times higher than estimated by parents; five behaviors were 10 more prevalent than parents reported (Young and

Zimmerman, 1998). Intervention and support is unlikely if parents are unaware of such risk behaviors.

More internal symptoms such as anhedonia, hopelessness, worthlessness, and depression may not be known to parents (Brent et al., 1994, 1996; Brent, 1999). Studies of parental knowledge of their adolescents' state of mind is needed to clarify directions for future inquiry. Parents need to be informed of the degree of miscommunication between the parent and adolescent. Qualitative study is the most appropriate means to establish rapport with parents and engage them in an in-depth discussion of feelings to allow for reminiscences and reveal denial to the investigator.

Communication of intent of suicide is seldom an overt threat. Instead, the adolescent's degree of social integration with the most basic of social units, the family, steadily declines. Isolation decreases societal pressure to conform (to the taboo of suicide). The adolescent becomes increasingly hopeless, sees no solution to problems Communication of intent of suicide is seldom an overt threat. Instead, the adolescent's degree of social integration with the most basic of social units, the family, steadily declines. Isolation decreases societal pressure to conform (especially to the taboo of suicide). The adolescent becomes increasingly hopeless and sees no solution to problems (Beck et al., 1979). The adolescent may reach out with mostly non-verbal signals that are inconsistent and disorganized and may be difficult to recognize. The adolescents' learned style of communication distorts the message. Hopelessness mounts, social integration decreases, disequilibrium ensues, and suicide is the outcome without intervention.

The significance of a study is directly related to its social ramifications.

Adolescent suicide, a national public health crisis, desperately needs investigation into

the variables of adolescent suicide.

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Appendix

Appendix. Copyright permission letter for use of Risk-Rescue Rating Scale.

Permission Granted Notification

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