INTRAFAMILIAL FACTORS ASSOCIATED WITH ADOLESCENT SUICIDE

GAIL RAINES HUDSON

INTRAFAMILIAL FACTORS

ASSOCIATED WITH

ADOLESCENT SUICIDE

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Master of Arts

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by

Gail Raines Hudson

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To the Graduate and Research Council:

I am submitting herewith a Research Paper written by Gail Raines Hudson entitled "Intrafamilial Factors Associated With Adolescent Suicide." I have examined the final copy of this paper for form and content, and I recommend that it be accepted in partial fulfillment of the requirement for the degree Masters of Arts, with a major in Psychology.

Major Professor

We have read this Research Paper and recommend its acceptance:

Second Committee Member

Third Committee Member

Accepted for the Graduate and Research Council:

Dean of the Graduate School

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter I

INTRODUCTION

Attempted and completed suicides among adolescent populations continue to be a major concern in many communities. Adolescent suicides are currently higher than ever recorded. In 1977, three thousand adolescents committed suicide, an average of thirteen a day (McKenry, Tishler, & Kelley, 1982). Presently, suicide is the third cause of deaths among 15 to 24 year olds. It is preceded only by accidents and homicides, many of which may be unreported suicides.

In the last twenty years adolescent suicide has increased 300% (Douglas, 1986). Males have increased in completed suicides because they use more violent means, while females have increased in attempted suicides, perhaps because they use more passive means (Hawton, 1988).

See Figure 1

The incidence of suicide is compounded when the number of attempts are compared to the number of completed suicides. The estimated ratio is two hundred to one, suggesting that one million attempts are made each year in the United States alone (Godwin, 1986).

According to Hawton (1988), the most successful means of suicide is firearms, which is increasing among adolescents age 15 to 24 years. In younger adolescents, age 10 to 14 years, guns are used in approximately half of the suicides. One third of the suicidal deaths in this age group were by hanging. Boys were more likely than girls to use violent methods such as guns and hangings, and girls were more likely to use drugs. These findings suggest that adolescents use

whatever methods of suicide that are readily available and familiar.

See Figure 2

See Table 1

The usual methods of studying the causes of suicide are through "psychological postmortems" and "post suicide interviews" (Hawton, 1988; Keitner, Miller, Fruzzelli, Epstein, Bishop, & Norman, 1987). The psychological postmortem is a procedure of obtaining data from family members and social agencies following a suicide. After collecting family data, a profile of the deceased's background and precipitating events is constructed. There are significant problems with this methodology since it is retrospective. The data collected may be biased because of parental feelings of personal guilt and overprotectiveness of the deceased's reputation. There may also be a distortion of time; events lose context as memory becomes diffused (Hawton).

A second source of postmortem data consists of information collected from social agencies, such as schools, family physicians, or service agencies. These data lack important personal details, such as the deceased's personality traits, interpersonal relationships, concerns, and other emotional variables (Hawton, 1988).

Through post suicidal interviews researchers collect data from adolescents after the attempted suicide. Problems include interviewing depressed and withdrawn adolescents who may refuse to cooperate (Hawton, 1988). Their perspective may be distorted by depression and by their feelings of hopelessness (Keitner et al.,

1985). Sometimes little relevant information is gained.

The motives of suicidal adolescents are complicated and often contradictory. Traditional risk factors include emotional problems, social withdrawal, significant losses, and substance abuse. However, many adolescents experiencing these factors do not attempt suicide. Recently, factors involving intrafamilial dysfunctions have been researched to determine the discrepancy between these two groups.

Rosenbrantz (cited in McKenry et al., 1982) stated that family conflict, parental disharmony, and parental rejection are related to adolescent suicide. Among clinically depressed adolescents, those who commit suicide are more likely to have intrafamilial disturbances, particularly in the adolescent-father relationship (Kosky, Silburn, & Zubrick, 1986). These disturbed relationships were characterized by persistent conflict between adolescents and fathers, culminating in adolescent's feelings of rejection and hopelessness. Teicher and Jacobs (cited in McKenry et al.) stated that adolescent suicidal behavior is a developmental variable in families dominated by marital conflict, poor parent-child relationships, and parental rejection. He also stated that dysfunctional parent-child relationships prevent adolescents from obtaining the nurtured socialization, supportive relationships, and successful modeling necessary for coping with the adolescent stage.

This paper focuses on the relationship between the mother-father-adolescent triad and suicidal behavior. Specifically, this paper addresses marital cohesion, parental control, and parental rejection. Issues in parental interactions with adolescents and adolescents' perceptions of those interactions will be addressed.

Chapter 2

REVIEW OF THE LITERATURE

In 1983, Kosky conducted research on the causes of suicide among adolescents. He reviewed all suicidal admissions to an inpatient psychiatric unit for children over a four year period, comparing this group to a randomly selected group of psychiatric admissions to the same hospital. The suicidal group consisted of twenty children under 14 years of age and the control group consisted of 50 psychiatrically ill, non-suicidal children of the same age. Results revealed a three to one ratio of males to females attempting suicide. Sixty-five percent used violent methods; hanging and strangulation were the most common methods. Eight-five percent of the suicidal subjects reported sleep disturbances, 90% were unhappy or depressed, 85% were angry and hostile, and 65% were anxious. None were physically handicapped or delinquent by diagnosis.

Significant losses were experienced by 80% of the suicidal subjects and 20% of the control group. Losses consisted of the following:

Loss of a parent or parents by death or separation

Loss of a grandparent by death

Loss of a sibling by death

Loss of a pet

Furthermore, 60% of the suicidal subjects had experienced the loss within the past year; 30% had more than one loss with which to contend.

A review of family structure revealed that 60% of the suicidal subjects were living with only one natural parent at the time of their

attempt. By contrast, 82% of the control subjects were living with both parents. Within both groups there was a high incidence of parent or sibling illness at the time of the subject's admission to the hospital; however, suicidal adolescents had more parents with depressive illnesses.

The most striking factors revealed in Kosky's (1983) research were the degrees of violence and loss in the families of suicidal subjects. Six and one-half percent reported witnessing arguments resulting in physical violence between their parents. Sixty percent were targets of parental physical abuse. The incidence of marital disintegration was also significantly high; half were divorced. One-third experienced multiple losses. The loss of the father was significant because of the economic implications and increased stresses of living in a female headed family.

Kosky (1983) suggested that high levels of violence and loss found in the families of suicidal adolescents tend to produce angry adolescents who are prohibited from expressing their anger outside the family; therefore, they tend to become victims within the family. These victimized adolescents internalize their anger, turning it into self-hatred and suicidal behavior.

Hawton (1988) reported child abuse in 60% of suicidal adolescent cases. He hypothesized that the abused adolescents' sense of worthlessness and self hatred resulted in internalized patterns of self destructive behaviors. Hendin (1987) concurred, reporting that more suicidal adolescents had fathers who were physically violent and mothers who left them with physically violent substitutes. These adolescents described their parents as alienated, resentful, hostile, and rejecting.

Four hundred and six consecutive suicide attempts made by 15 to 19 year old adolescents between 1973 and 1982 were researched by Kotila and Lonnqvist (1987) to determine the variables involved in repeated suicide attempts. Two hundred and twenty-six cases were first attempters and 180 were repeaters, of which 28% were boys and 72% girls. They researched past psychiatric history, previous suicide attempts, the means of the present suicide attempts, diagnoses, and subsequent treatment plans.

Results revealed no significant differences between first-time attempters and repeaters regarding the death or separation of their parents; however, familial disturbances were found in 60% of repeaters and only 40% of first-timers. Sixteen percent of the repeaters had no permanent residence compared to 4% of the first-timers. They concluded that repeaters were more likely to come from unstable homes where parental-adolescent relationships were marked with inconsistency, rejection, and hostility. By the end of their study, 62% of first attempters and repeaters had died from suicide. Further investigation revealed that in these cases negative familial factors had escalated prior to their deaths.

Familial disruptions were also found to be significant in the research conducted by Tishler, McKenry, and Morgan (1981). One hundred and eight adolescents who attempted suicide were investigated over a two year period. Factors emphasized were suicidal intent, likelihood of repetition, demographic variables, and familial background information. Results revealed 50% had parents who were separated or divorced; however, 60% of those from intact families stated their parents' marriages were poor. Family disruptions consisted of marital

instability and unhappiness, disruption of residence, and inadequate parental functioning. Tishler et al. concluded that dysfunctional parent-adolescent relations result in adolescents feeling rejected and unloved.

Tishler et al. (1981) stated that dysfunctional family patterns impair coping skills of adolescents. Dysfunctional parents serve as models which offer the cognitively immature adolescent negative solutions to problems. Subsequently, normal adolescent adjustment problems, when reacted to negatively, escalate into unmanageable situations for adolescents. Tishler stated that adolescent suicide is, therefore, a developmental or progressional disorder.

Parent-Adolescent Interactions

Little has been researched on the specific variables of parent-adolescent interactions which may precipitate adolescent suicidal behavior. McKenry, Tishler, and Kelley (1982) administered questionnaires to 92 adolescents, ages 12 to 18 years, who were admitted to a hospital emergency room. Forty-six were admitted for attempted suicides, while a control group of 46 nonsuicidal adolescents were admitted for minor injuries.

The results indicated that adolescent attempters reported a more negative view of their relationship with their parents than the control group. They reported time spent with parents as less enjoyable, their parents' marriage as less well adjusted, and their mothers as significantly less interested in them. Father's behavior, however, was reported not to be a significant factor. Questionnaires completed by parents of attempters concurred with these findings. Additionally, the parents reported unfavorable views of their spouses' parenting

skills, fathers with more depression, and mothers with more anxiety.

These findings were verified by others. Fine (1980) reported that marital discord with continued threat of dissolution, lack of communication between parents and adolescents, and poor coping skills contribute to adolescent suicidal ideations. Hawton's (1988) review of the research literature concurred, reporting that family disruption, parental rejection, and inadequate care were significant determinants of suicidal behavior in adolescents.

Two hundred and seven high school students and ninety college students were administered questionnaires to investigate their degree of family stress, childhood happiness, substance abuse, and delinquent behavior (Wright, 1985). Over 10% of high school and over 6% of college students reported suicidal ideation. They reported that their parents had marital conflicts, that their relationship with their father was poor, and that at least one of their parents was angry or depressed. They also reported themselves to have drug problems. Parental permissiveness, maternal drinking, and a poor mother-adolescent relationship were not found to be significant predictors of suicidal ideation among this group.

The studies reviewed consistently stressed the role of parent-adolescent relations. Dysfunctional family patterns of parental neglect, parental rejection, parental modeling of inadequate coping skills, and faulty communication skills are crucial to understanding the processes involved in adolescent suicide.

Marital Cohesion

Emphasis is often placed on the family constellation and how it relates to adolescent suicide. The question of whether the loss of a

parent itself or the circumstances surrounding that loss is the more crucial factor in predicting suicidal behavior was researched by Adams, Bouckons, and Streiner (1982). They compared 98 adolescents who had attempted suicide with 102 matched controls for the incidence of parental loss and family stability. Detailed information on family background was collected in semi-structured clinical interviews. Emphasis was placed on familial losses, separations, and parental care. Patterns were recorded as stable, unstable, or chaotic. Stable familial patterns were operationalized to include consistent and adequate parental care without material hardships. Unstable patterns consisted of inconsistent but adequate parental care with or without material hardships. Chaotic patterns consisted of gross deprivation of adequate parental care associated with prolonged separation from parental figures and prolonged material and emotional deprivation.

The research revealed that suicide attempts were significantly higher in adolescent groups who had experienced losses from parental separation, divorce, or death. Fraternal deaths were more significant to later attempts than were maternal deaths; however, there was a highly significant relationship between family stability and adolescent suicide in all groups. Nine percent of adolescent attempters were rated as having a stable long term family environment compared to 60% of the control group. Furthermore, 91% of attempters were rated as having an unstable or chaotic family environment compared to 40% of the controls. Of subjects experiencing a parental loss, attempters reported more family instability prior to the loss than nonattempters. Both groups reported decreases in family stability after the loss event.

Adams et al. (1982) then compared adolescents who experienced parental loss with those from intact families. Fourteen percent of adolescent attempters from intact families had stable homes, 65% had unstable homes, and 21% had chaotic homes. Adolescent attempters experienced unstable or chaotic family environments more often, irregardless of family constellation. Investigation also revealed a significant relationship between long term family instability and suicidal ideation. Ninety-five percent of those with chaotic homes and 62% with unstable homes had experienced suicidal ideations, while only 20% came from stable homes.

Adams et al. (1982) concluded that a majority of adolescent attempters come from unstable or chaotic family environments, regardless of parental loss. These findings question the validity of the assumptions that parental loss predicts adolescent suicide. Parental loss may only be an intervening variable to this complex phenomenon.

Depression and Family Cohesion

Depression has also been correlated with adolescent suicide, however, little is known as to why some depressed adolescents commit suicide and some do not. Kosky, Silburn, and Zubrick (1986) compared adolescent psychiatric outpatients who were diagnosed with depression. One group experienced suicidal ideations while the other did not. Data were gathered on family, school, and social background using an interview format. The research revealed that the suicidal ideation group was more likely to have disturbances in adolescent-father relationships, whereas both groups reported disturbed adolescent-mother relationships. These disturbed relationships were composed of

persistent parental conflict, persecution, and hostility directed toward the adolescent, and child abuse. There was, however, no difference revealed between the groups in relation to parental loss. Kosky et al. suggested that disturbed and hostile intrafamilial relationships produce emotional stress within adolescents which leads to suicide; and that dysfunctional familial relationships may be the principle variable to the increasing rates of adolescent suicide.

Further research between depressed attempters and depressed nonattempters was conducted by Friedrich, Reams, and Jacobs (1982). They had 132 high school adolescents, ranging in ages from 13 to 16 years, complete the Beck Depression Inventory, the Sensation Seeking Scale, and the Family Environment Scale. Additional data were gathered using a biographical data sheet, a social support index, and a life stress inventory. The subjects were grouped into three levels of depression - mild, moderate, and severe.

The research revealed that depression in adolescents is significantly related to the number of life stresses experienced, the degree of family cohesion, and the level of parental employment. Suicidal ideation, however, was related to family variables such as decreased cohesion, decreased commitment of family members, dysfunctional organizational patterns, and greater achievement orientations for adolescents by their parents. Recent life stresses were not related. The findings suggested that depression was more situational, while suicidal ideation was related to dysfunctional familial patterns that were ingrained over an extended period of time.

Cohen-Sander, Berman, and King (1982) concurred with Friedrick's et al. findings, however, their research differed in regard to the

implications of life stresses. Data were gathered from 76 children, age 5 to 14 years, who were discharged from an inpatient psychiatric hospital. Medical records were reviewed and the Life Stress Inventory, the Social Readjustment Scale for Children, and the Achenbach Symptom Checklist were given. Twenty of the children were defined as suicidal, 21 as depressed but not suicidal, and 35 as a control group. The suicidal children did not differ from the depressed or control group in age, sex, race, treatment history, weeks in current treatment, or family suicidal history.

Results revealed that depressed children were not necessarily suicidal and that suicidal children, whether depressed or not, experienced an increasing amount of life stressors, particularly during the year prior to the attempt. Factors associated with stress were as follows:

Being first born

Being overly enmeshed within the family and holding some special position

Experiencing family responses described as impulsive

Experiencing decreased family cohesion marked with marital conflict

It was suggested that suicidal children were subjected to parental modeling of inadequate coping skills consisting of the use of conflict, avoidance, and impulsivity. These children, as adolescents, would be unable to utilize adequate coping skills necessary for successful development through the adolescent stage. Subsequently, feelings of failure, incompetence, and self-hatred would evolve into suicidal behaviors.

The premise that depression is a major contributor to suicidal behavior in adolescents, therefore, has to be modified to account for particular life stresses found in dysfunctional families. Familial patterns of behavior were described by Godwin (1986) to include mothers who were cold, rejecting, and rigid and fathers who were passive, weak, rejecting, and absent. Poor and unhappy parent relations culminated in poor communication between parents and adolescents as revealed in McIntire and Angle's (cited in Godwin) research where 56% of adolescents stated they couldn't communicate with their parents. They perceived their parents as being hostile, indifferent, and rejecting.

Family cohesion was consistently found to be more important than familial losses through separation, divorce, or death. Adolescents repeatedly stated that marital conflict was of greater detriment than living within single households.

Parental Control

Parental control was researched by Harbin (1980), Pfeffer (1981), and Molin (1986) who reported that suicidal behaviors were linked to family patterns reflective of both over or under control by parents.

Harbin (1980) researched overly enmeshed family patterns evidenced in cases he treated. Adolescents were found to have a close symbiotic, emotional bonding with one parent, while the other was only indirectly or ineffectually involved. Within these families, adolescents were prevented from separating through manipulations of the symbiotic parent in order to decrease overt marital conflict and keep the marriage intact. He suggested that suicide may be adaptive or protective to some families in that it sublimates family stress onto adolescents.

According to Pfeffer (1981), adolescents in overly enmeshed

families have the special role of providing gratification to one parent, of being that parent's protector, and of displacing that parent's hostility. These families are inflexible with closed boundaries which prevent needed adjustments for adolescent separation. Denial, decreased communication, and withdrawal of support are used by parents to prevent changes (Sands & Dixon, 1986). Interactions between spouses are conflictual, and often intense anger is openly projected onto their adolescents. A high priority is placed on the existence of the spouse's bond at the expense of all other family members (Aldridge & Dallos, 1986). Adolescents internalize the family conflict and feel they are the source of the parent's problems. They may feel guilty and rejected, balancing the preservation of the family unit with their own process of separating.

Enmeshed families were likewise identified by Molin (1986). He included parental patterns of underenmeshment as contributing factors to adolescent suicide. These parents projected patterns of rejection, negative communications, and the withholding of approval. Control was sporadic with alternating periods of concern and indifference. Intense ambivalence, rigid patterns of interaction, and poor identity as a family unit were correlated to adolescent depression. Senior (1988) stated that adolescents in underenmeshed families fail to receive necessary support systems which are needed for successful adolescent development and separation.

Adolescent Perceptions of Family Interactions

Topol and Reznikoff (1982) researched adolescent's perceptions of their intrafamilial relationships. Thirty hospitalized suicidal adolescents were compared with 34 hospitalized nonsuicidal

adolescents and 35 nonhospitalized adolescents. The Mooney Problem Checklist, the Norvicki-Strickland Locus of Control Scale for Children, the Family Concept Test, the Beck-Weissman-Lester-Trexler Hopelessness Scale, and the Marlowe-Crown Social Desirability Scale were used to assess adolescents' perceptions of family relationships, hopelessness, and locus of control.

The research revealed that suicidal adolescents felt they had significantly more severe family problems. They stated there was no one in their family to whom they could confide. Eleven of the 30 suicidal adolescents discussed problems with no one, while three of the controls confided with family members. The suicidal adolescents reported their families as least well adjusted, unavailable, rejecting, and overprotective.

Hendin (1987) reported similar findings. His research revealed suicidal adolescents' perceptions of parents to include resentment, hostility, and rejection. They reported profound difficulties in their parent-adolescent relationships. They felt their parents wanted them physically but not emotionally; and although expected to fulfill parental demands, they were not emotionally supported when they tried.

Negative perceptions of family interactions are correlated with feelings of hopelessness, depression, and self-hatred. Carlson, Asarnow, and Guthrie (1987) researched 30 children, age 8 to 13 years, who were psychiatric inpatients. They used the Depression Self-Rating Scale, the Perceived Competence Scale for Children, the Family Environment Scale, and the Coping Strategies Test to identify variables associated with depression and suicidal behavior.

The strongest predictor of suicide was children's perceptions

of their family environment. Suicidal children perceived their parents as unsupportive and in greater conflict; they reported less control over events within the family, greater hopelessness and depression, and feelings of being overwhelmed and out of control.

While adolescents' perceptions of their families yields valuable insight, parental perceptions also are of value. Keitner, Miller, Fruzelli, Epstein, Bishop, and Norman (1987) compared perceptions of adolescents with their parents to determine if a discrepancy existed. The hospital records of 44 adolescent attempters, 24 non-attempters, and 50 with suicide ideations were reviewed. A matched sample of 124 non-clinical families was used as a control group. Family functioning was assessed using the Family Assessment Device which identifies six dimensions of family functioning: problem solving ability, communication styles, family roles, affective responsiveness, affective involvement, and behavioral control.

Keitner's et al. (1987) research revealed that suicidal behavior was associated with a discrepancy between adolescents' and parents' perceptions of family relations. Suicidal and suicidal ideation adolescents reported poor family functioning in problem solving ability, communication effectiveness, familial roles, and overall general functioning. Affective responsiveness, affective involvement, and behavior control were less related. Suicidal and suicidal ideation adolescents also reported poorer family functioning than did their respective parents; nonsuicidal adolescents and their parents reported comparable positive views. Keitner suggested that it is the discrepancy between family perceptions that may distinguish suicidal from nonsuicidal behavior. Keitner stated that parents may be

misperceiving family difficulty, reflecting a denial process rather than adolescents misperceiving because of depression.

Tolor's (1986) research on the perception of adolescent suicide concurred with others. Undergraduate students, graduate students, and the general population reported their perceptions of adolescent suicide to be caused by a decline in family cohesion. Cohesion included communication, support, love, and affection. There was a consensus that suicidal behavior in adolescents was not due to any basic personal deficiency, but deficiencies within familial functioning.

An Unsolvable Problem

Evans (1982) and Orbach (1986) summarized the research on adolescent suicide. They concluded that adolescent suicidal behavior is a complex phenomenon that is multifactored; a particular cause cannot be isolated. These adolescents live within an intolerable life situation which creates for them an "unsolvable problem" (Orbach, 1986). This unsolvable problem makes the adolescent feel trapped and incapacitated. Orbach described the problem as being beyond their ability to resolve because it is deeply rooted in the life of the entire family as a unit. It is multidetermined and long-standing. It is also often disguised by other family members or family dynamics. These adolescents are confronted with disintegrating families who are trying to stay together, families where prolonged anger between parents is suppressed and projected onto adolescents, and families who force their children to compensate for parental failures and disappointments.

Adolescents, according to Orbach (1986), are limited in their solutions to the problem by restrictive parental alternatives. Parents may limit alternatives to one possibility only, which is usually

undesirable. They may place their adolescents in a "double bind." The adolescent is encouraged to take a certain course of action but then that action is blocked. Even successful resolutions may create new problems so that adolescents are constantly confronted with problems or conflicts which they often can't even identify. When conflict is constant and hidden, but is accompanied by pressure to do something, a feeling of fighting against a powerful force emerges. This feeling manifests itself in adolescent guilt and self hatred.

Orbach (1986) emphasized that the problem concerns the entire family as a system. It is not just between adolescents and parents; nor is it a single dissatisfaction of a single need by a single individual. The roots are multidimensional and they are formed during early childhood. The accumulation of failures to satisfy parents and the emergence of new problems leave adolescents with inner frustration, guilt, and hopelessness. Their identity becomes dominated by images of failure, a negative perspective of the world, and a rigid approach in coping with problems in the future. Guilt and depression escalates until adolescents become so helpless and hopeless that suicide is perceived as their only action of escape.

Chapter 3

CONCLUSION

The findings in this research review emphasize that variables related to adolescent suicide must be evaluated within the total context of adolescents' social-psychological history. Adolescents from dysfunctional families are more vulnerable to suicide due to the development of negative perspectives and impaired coping skills modeled by parents. Subsequently, they are unable to cope with particular physical and emotional changes inherent to the adolescent developmental phase. Normal adolescent developmental adjustment problems become unmanageable stress situations. Additionally, support systems through family relationships are negated for scapegoating techniques that protect the family structure. Based on this premise, adolescent suicide can be viewed as a developmental disorder within a familial network of dysfunctional patterns.

Adolescents in dysfunctional families develop feelings of helplessness and vulnerability which are nurtured by familial patterns of marital conflict, parental rejection, and disturbed modes of parental control and communication. Many of the findings stressed that the adolescent's home environment was the most significant factor in susceptibility to suicide. Parents of adolescents who attempt suicide were consistently found to be more hostile and indifferent, demonstrating more overt and covert rejection, more inconsistency in control, more instability in family structures, and less personal support. A resulting conclusion is the development of adolescent feelings of unworthiness, incompetency, guilt, and rejection. This negative environment is not likely to provide the optimal ego

development, identity formation, and intimacy roles necessary for the resolution of current and future problems. Additionally, dysfunctional family relations and negative self reflections restrict adolescents' ability to separate and individuate.

Adolescents in dysfunctional families are also pressured to solve problems inherent within their families; but they lack the solutions to do so. The problematic situation is unsolvable because it is beyond their ability, the alternatives are limited, and resolutions create new problems. Inability to resolve familial problems creates an external locus of control where adolescents experience feelings of powerlessness over what happens to them. There is no emotional support in the family structure because all of the members are involved within the problem. This "double bind" situation increases adolescents' feelings of hopelessness and worthlessness.

There are problems inherent to this research. Definitions of crucial concepts such as rejection, cohesion, communication, and support are inconsistent and difficult to operationalize; therefore, the exact meaning of each is suspect. For instance, what does familial rejection include? Is it material rejection involving nonprovision of food, clothing, and other necessities of life, or is it emotional rejection involving more subjective factors such as love, affection, or nurturance. And if it is the latter, what does each entail. Additionally, what is cohesion and what does it involve? Is it the number of family members present or is it more subjective; and if so, what variables differentiate a cohesive from a noncohesive family? The point must be made, therefore, that research in this area is subjective and multidimensional. As a result caution needs to be exercised in accepting the overall conclusion.

A secondary issue that is problematic to this research is the importance of the role of fathers. The research findings are contradictory, with some studies emphasizing the importance of the father-adolescent relationship and others deemphasizing it. In some studies fathers were excused because of adolescents' perceptions that they be uninvolved and absent by virtue of their economic roles. Therefore, mothers bore the responsibility of providing nurturance and support. Implicated within this issue are mothers' changing roles, where economic pressures are forcing them into job markets and out of homes. If adolescents dismiss the mother's contributions to the family as easily as research stated they did fathers, then adolescents will become even more isolated. Without support and nurturance from either parents, adolescents may find themselves at risk for increased suicidal behaviors.

Future Research

Future research addressing parental-adolescent interactions and suicide may need to objectify its format. Research designed to operationalize terms such as rejection, communication, and cohesion would lend more credence to its findings.

As a means of clarification, rejection could be operationalized to include the following specific criteria.

1. Ignoring adolescents when approached by them.

2. Failure to express affection to adolescents. Affections to include hugging, touching, and verbal statements of love, praise, and encouragement.

3. Failure to spend quality time with adolescents. Quality time to include periods of sharing adolescent interests, periods of intimate conversations, and the exchange of goals and ambitions.

Communication could also be operationalized to include the following criteria.

1. The number of times parents and adolescents converse on intimate and nonintimate matters.

2. The adolescents' perceptions of parental communication styles such as open versus closed and preaching versus guiding.

3. The patterns of listening and talking by each member, that is, who talks more and who listens more.

4. How decision making modes of communication are conducted, is it an egalitarian process or are some members more dominant than others.

And lastly, the term cohesion could be clarified to include the following criteria.

1. The number of family members, the roles of each, and the coalitions formed.

2. Problem solving strategies employed by individual family members and the family as a unit.

3. Goals of the individual family members and the family as a unit.

4. The affective dimensions and emotional bonding between family members.

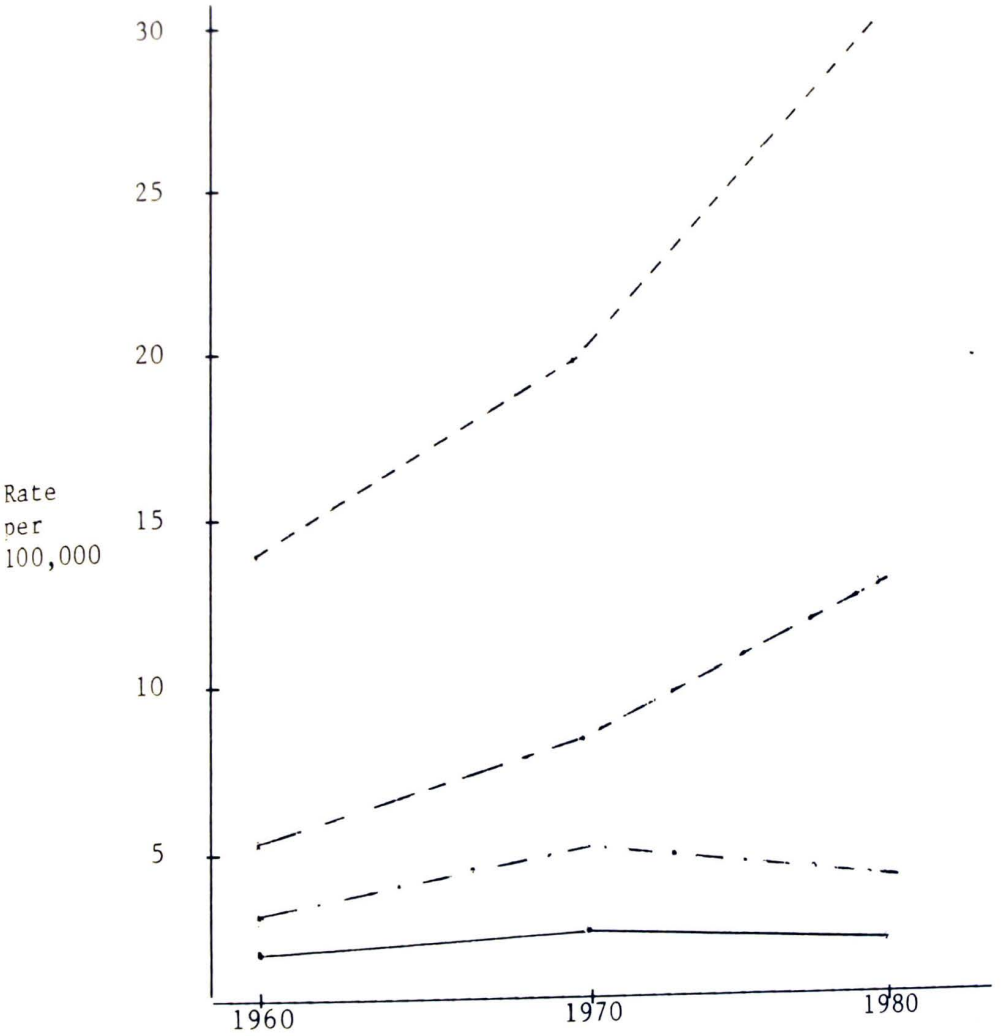
Secondarily, research addressing the specific role of fathers to intrafamilial processes and adolescent suicide would be helpful in understanding and clarifying the contradictory findings regarding their roles. More emphasis on adolescents' perceptions of fathers' roles and their noninvolvement needs to be addressed. Questions such as numbers and degrees of quality time spent and communications

exchanged should be explored. Indepth interviews exploring adolescents' feelings regarding fathers' uninvolvement and adolescents' expectations should be compared to families where the father is actively involved.

Adolescent suicide, as stated, is a complex and multidimensional phenomenon with its roots beginning early in the life of a child. It is a developmental process born of familial interrelationships that are often dysfunctional and destructive. Therefore, increasing positive intrafamilial relationships may be a major factor in preventing suicidal behavior by adolescents. It is our responsibility, as adults and parents, to provide our adolescents with the positive modeling and intimacy to guarantee their development into healthy and happy adults.

Figure 1

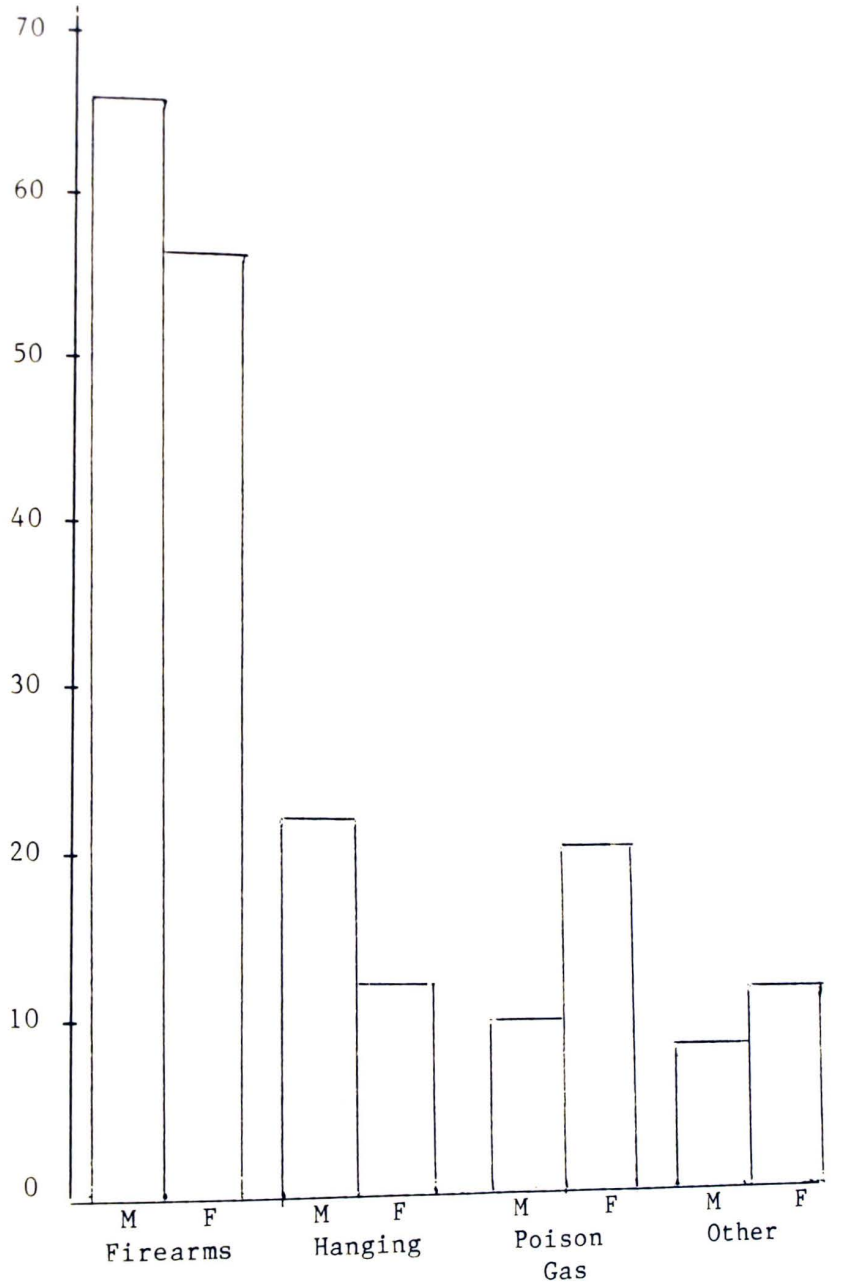
Suicide rates (per 100,000) for males and females age 15 to 19 years and 20 to 24 years in the United States, 1960-1981.



Note. From Suicide and attempted suicide among children and adolescents by K. Hawton, 1988, CA: Sage Publications.

Figure 2

Method and percentages of completed suicide, males and females, ages 10-19 years, 1978.



Note. From "The troubled teen: suicide, drug use, and running away" by B. Sommer, 1984, Women and Health, 9.

Table 1

Methods and percentages used in suicides by children and adolescents in the United States (1981) and in England and Wales (1983).

Methods	10-14 United States (Percentages)	15-19 United States (Percentages)	England & Wales (Percentages)
Firearms	52.9	66.0	5.9
Hanging, strangling, and suffocation	32.0	18.0	29.4
Poisoning by liquids and solids	.8	2.2	23.5
Poisoning by gas	0.6	7.8	5.9
Other	1.7	5.9	35.3*

*Jumping from high places was common in England and Wales.

Note. From Suicide and attempted suicide among children and adolescents by K. Hawton, 1988, CA: Sage Publications.

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