

College Student Suicide

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Adolescence is a period of experimentation and adjustment for many young people, but this is also the age when we shed our childhood supports while assuming adult responsibilities. This is the age when major psychiatric illnesses become manifest -- most of us can look back on the stresses and emotional storms that marked our teenage years, but since the 1950's more and more teenagers and young adults have found the strain unbearable. Their despair is reflected in the tripling of the teenage and young adult suicide rates from the 1950s to the mid-80s, when it began to level off.

Although alarmist fears of high college suicide rates intermittently fill the newspapers, college students do not commit suicide more often than do other young adults. Yet suicide is the second leading cause of death among college students -- after accidents. It is a cause that is exceedingly difficult to investigate: because few college students commit suicide, the small or otherwise limited studies that examine college suicide can suggest only some very tentative findings. Despite their limitations, some of these studies make the disturbing suggestion that certain student groups may have considerably higher rates of suicide, and that suicide may be more prevalent among students attending some elite schools in the U.S., England and Japan.

The elevated suicide rate found among foreign students in American and British schools is one such striking finding. In the 1950s, when this was last studied, foreign students were found to have annual suicide rates of 80 per 100,000 -- many times higher than the rate of their non-foreign peers. Social isolation is an especially severe problem for these foreign students and their high suicide rate may underline the importance of social isolation in fostering suicide.

Psychosis and depression are other risk factors for suicide in college students, just as they are in the general population. Suicide is not more frequent in any of the four years of college, but it does occur more often in students who take more than four years to earn their degrees, probably because this group includes many students whose studies were interrupted by serious depression.

College students who commit suicide show different personality traits than non student suicides. Most young adults who commit suicide have impulsive, high risk-taking personalities, and the abuse of drugs and alcohol is frequent in this group. College suicides, by contrast, are largely depressed, quiet, socially isolated young people who do not abuse alcohol or drugs, and who draw little attention to themselves.

Many college students feel chronically depressed, worthless and rejected by their families, and they struggle to gain some measure of acceptance and worth through academic achievement or athletic success. The inner life of such a chronically depressed person is not a slumbering state of dull unhappiness, but a confused melange of contradictory feelings of self-loathing and hate for the very people from whom he seeks love, the parents whom he feels have so hurt and frustrated him. Academic drudgery in the service of winning parental love perpetuates these students' connections with their parents, even as it threatens these connections by edging the student closer to graduating into an autonomous life.

The students who move beyond depression into suicide possess an additional attraction to death itself, which is seen as a soothing comfort and as a device for cementing a union with approving parents. They hold fantasies of rebirth as good, "cleansed" people; fantasies of returning to a world made better by their death; fantasies of reunion with loving people. These fantasies may help suicidal individuals to function and adapt in the world, but when they are profoundly stressed by interpersonal losses or academic setbacks, they mobilize plans to enact these fantasies.

Many suicidal students experience anxiety, insomnia, and other symptoms, though these may disappear shortly before the suicidal act, as the plan to commit suicide provides a seeming solution to their psychic pain. Those whose symptoms remit when they activate their suicide plans may be especially resistant to

seeking any help that entails reexamining and reexperiencing the issues that so depressed them. When they do go for help, few report their suicidal intent, and few receive any psychiatric treatment, even though nearly half the suicidal students present for some medical treatment in the months before committing suicide.

While most suicidal students draw little attention to themselves, their multi-year residence in the monitored college environment offers the possibility that a sufficiently determined effort could detect suicidal students and press them into treatment. Teachers, coaches, and residence hall counselors should focus not only on disruptive students, but also on those who are quietly withdrawn whose dormitory discussions or classroom essays may disclose their hopelessness and suicidal interest.

Once suicidal students are detected, schools hold considerable ability to assure their compliance with treatment. In the past, students who were recognized to have any interest in suicide were promptly sent home on medical leave. Students are not well served by such policies that impose automatic medical leaves and return them stigmatized into families that may be chaotically disorganized. For many, a supportive campus setting enables them to continue their studies while receiving treatment.

Schools should prepare postvention plans in case a suicide does occur on the campus. The plans should focus on outreach to survivors and on preventing suicide contagion by managing the information that is presented to the press and public. As few suicides occur on each campus, however, few schools have prepared such plans for managing the acute disruption in campus life that follows a suicide.

Further reading:

Schwartz AJ and Whitaker LC. Suicide among college students: Assessment, treatment and intervention. In SJ Blumenthal & DJ Kupfer (Eds) *Suicide over the life cycle: Risk factors, assessment, and treatment of suicidal patients*. (pp. 303-340). Washington DC: American Psychiatric Press, 1990.

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