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Exam culture and suicidal behaviour among young people

This article is concerned with the mounting evidence that examination and assessment pressures have caused a rise in mental health problems in some countries and that this may be a growing contributive factor in increasing suicidal behaviour among young people.

Definition

Suicidal behaviour has been defined as an 'act of deliberate self-harm with at least some intent to die' (Silverman et al., 2007: 264). The risk factors which may lead to suicide are many, and it is accepted that there may be overlapping causes. They include mental disorders, (particularly depression), substance use, stressful life events, social isolation, a family history of suicide, loss (social, financial, or relational), physical illness, low educational achievement and an unwillingness to seek help, (perhaps because of the stigma attached to mental illness) (Hawton et al., 2012). The literature on the subject has demonstrated the complexity of the issues involved, but some clear patterns have been recognized which appear to be specific to different cultures, geographical regions and to different age groups. (Hawton et al. 2012).

Statistical limitations

Statistics show that suicide rates are high in some countries, e.g. Lithuania, and lower in others, e.g. Australia, (World Health Organization, 2012). Some of this variation is unrelated to the risk factors that may lead to a person taking their own life. Reporting restrictions, cultural taboos, and even different definitions of what actually counts as suicide are a cause of substantial discrepancies in reporting (Silverman, 2006). Coroners may not know if a death was accidental, has multiple causes or is the result of suicide and may often offer an undetermined/open verdict when causes are uncertain. Major religions and philosophies oppose suicidal behaviour and in some countries it remains illegal: this also compounds under-reporting.

Understanding the causes of suicidal behaviour in young people and children remains a major challenge. For young people the data define children/adolescents in different ways, with different age cut-offs, so statistics have to be treated with some caution. Making comparisons year-on-year or between countries can be difficult. However, there is sufficient information to make some general comments. I briefly summarize significant details below and where possible relate these to examination or school performance.

Suicide and self harm in the young

Worldwide, suicide has been stated as the leading cause of death among females aged 15-19 and is third for males of the same age. Figures indicate that around the world at least 164,000 adolescents kill themselves every year and an estimated four million attempt suicide. Youth suicide, worldwide, is increasing at a greater rate than other age groups (Wasserman, 2005). Younger people are at a higher risk of suicide than older people (Patton et al., 2009).

In the UK, suicide rates are not published at all for those under 15. In 2011, for young adults 15-19, suicide is the second most common cause of death after road traffic accidents (ONS, 2011). The number of children and young people who talked to ChildLine UK about suicide (either as their main problem or as an additional problem) more than doubled in the five years 2004-2008. 2,291 young people called because they were feeling suicidal and this was their main reason for calling. 93% of these were aged 12-18. (NSPCC, 2009a).

In the general population, following an act of self-harm, the rate of suicide increases to

between 50 and 100 times (Hawton et al., 2003b). Fox and Hawton (2004), estimate that between 40 to 100 times as many young people have engaged in self-harm than rather actually end their lives (NSPCC, 2009b).

ChildLine has reported a 59% increase in the number of self-harm callers in 2010-2011 compared to the previous year. 86% of the respondents admitted that depression was the main reason for calling. They also admitted to hurting themselves as a way of 'coping'. (NSPCC, 2012). The statistics on self-harm for young people in the UK are unreliable for a number of reasons. Many young people who self-harm will treat themselves or will be treated at home and will not reach the attention of services or professionals (Mental Health Foundation, 2006).

Suicidal behaviour and self-harming have multiple causes. Very little has been done to investigate any direct connection to school performance or examination stress, and indeed it would not be reasonable to look for single causes. However, school performance stress may be a contributing factor.

In a survey of 6020 students in 41 schools in England, it was found that 70% of those self-harming, with accompanying suicidal thoughts, had stated that this was because of worries about school work and exams. This figure was much higher than other stated problems; relationships, parents, bullying etc. (Samaritans, 2002). A survey by the UK Association of Teachers and Lecturers (2008) also found increasing mental health problems. 89% of teachers surveyed felt that tests and exams were the main cause of student stress. Other reports concur with this view. West and Sweeting (2003) found that school performance stress was having a profound affect on mental health, particularly among girls in the UK. Young Minds (2011), the UK mental health charity, is currently involved in a two-year project looking directly at the damage being done to children by the target-driven curriculum in England.

There are indications of rising cases of depression, self harm and suicidal behaviour in countries outside of the UK which also have a strong exam culture. Lee et al. (2009), in a survey of 3383 school students in Hong Kong, found a strong correlation between suicidal feelings and school failure and the pressure of

exams. A Social Welfare Department of Hong Kong Report (2010) concurred with this finding. The Hong Kong government has recently commissioned a report to investigate the issue because of a spate of school-age suicides. Seven of these suicides were identified as being related to school performance problems (Hong Kong Government, 2012). In mainland China, 24% of the 2500 middle school students surveyed in Shanghai had contemplated killing themselves, many stating that this was because of the stress of exams (Moxley, 2010). Suen & Yu (2006), report on exam-induced psychological and pathological problems in China, Hong Kong and other Asian countries. Hesketh, Ding & Jenkins (2002), also in China, note direct links between depression and suicidal feelings and fear of exams. Zeng & Le Tendre (1998) found a similar connection in a Japanese study.

In the UK, and in other countries around the world, indications are that the pressure from a developing exam culture appears to be putting increasing stresses on the young, stresses not felt to the same degree by previous generations. Greydanus & Calles (2007: 61) have reported that the mental health of the world's children has worsened, with "overall increases in stress and related problems ... school failure is seen as important factor in this".

The increase in management-based accountability systems in schools has been a developing phenomenon. The educational process in some countries has become almost synonymous with the process of testing and examination preparation. England may be at the forefront of this (House of Commons, 2007). Current trends in some countries for the 'corporization' of education in the name of efficiency and accountability may have altered views of education and its purposes in many countries (Kamens & McNeely, 2010).

The possible connection between increased exam pressure and mental health issues is something that has not yet been adequately researched. Suicidal behaviour, depression and self-harming have multiple causes which are biological, psychological and environmental. It is not always possible to see direct cause and effects links between exam stress and suicidal behaviour. However, the suggestion that the pressure of high-stakes exams is a contributing factor has to be given greater credibility.

The testing regimes, which have become prevalent in many countries in recent decades, have been given credit for the rise in education standards. We may also have to accept that test-driven education must take some of the blame for inducing behavioural and psychological problems.

What can be done?

In general terms, there is certainly an argument for moving away from what I call the 'business model' of education, with its stress on regulation, provable progress and league tables. Moving away from measurement-driven instruction to a more humanistic view of educational ideals would help. In this view, teaching the young to live happier and healthier lives, while promoting intellectual and emotional development are what matters.

A number of school-based programmes have been offered over the last 30 years to improve emotional health and knowledge about suicidal behaviour and depression. However, the success of these programmes has sometimes been seriously questioned. In some instances, evaluations have confirmed that students have attained an increased knowledge about suicidal behaviour, but concede that there is no evidence that that there has been a drop in suicide rates amongst the youth groups involved (Mazza, 1997). It is clear that such evidence would be hard to obtain: if a fall had been observed it might not have been related to a school's suicide prevention programme. There have also been suggestions that such programmes have made matters worse because programmes have 'normalized' suicidal behaviour by suggesting it occurs as a result of stress, rather than emphasizing that it is often a mental health issue. Stress, including stress about exams, may lead to suicidal behaviour, but education programmes have not given sufficient recognition to the mental issues involved.

Other critics have noted that the short programmes offered are wholly ineffective (some have been given only a 2-hour time slot in the whole of a student's school life). It has also been suggested that screening students for those most likely to be at risk would be helpful, rather than offering programmes to everyone.

In some states in the US suicide prevention programmes are required by law and this has led to more time being allotted to programme development. The Signs of Suicide programme (SOS, 2012), reports significant success for its curriculum, begun in 2000. "Significantly lower rates of suicide as well as more adaptive behaviour in attitudes to depression and stress" were reported (Aseltine et al., 2007). Grades 6-12 students involved in the programme learn about depression and suicide warning signs, risk factors, and how to get help. The programme seems to makes it clear that depression is recognized as a treatable illness and so perhaps removes the criticism that programmes normalize suicidal behaviour. Students are also screened for depression / suicide ideation and where necessary follow-up assessments are made.

Recent research in Japan found that around 40% of adolescents, who self-harmed in the previous year, did not seek help. Those who self-harmed were more likely to consult school nurses, which are present in all junior and senior high schools in the Japanese school system. It was recommended that school-based mental health should screen students at risk of self-harm, and educate school nurses about preventative care (Watanabe et al., 2012).

Another recent study, in the US, found that combining a youth suicide prevention curriculum with a home-based programme significantly reduced risk factors for suicidal behaviour. In this programme, 615 young people and their parents were involved. The combined method produced "significantly greater reductions in suicide risk factors and increases in protective factors..." (Hoover et al., 2012: 233).

Some practical ways in which help may be offered have been suggested by the DEAL support programme in the UK (Samaritans, 2012). This programme promotes emotional health and develops coping skills (problem solving, conflict resolution, communication, stress management etc.). It also offers lesson plans on understanding depression and suicidal feelings. The effectiveness of this programme has yet to be evaluated.

Also in the UK, approaches based on the tenets of positive psychology have also been used by Young Minds (2012a, 2012b) and by Wellington College (2012). Both include teaching materials to help students with

'resilience', 'character strength', 'meaning and purpose' and 'mental health'. Wellington College also states they have linked with parents to introduce this curriculum.

Knowledge of the issues often helps teachers, students and parents deal with the effects of stress, whatever form it may take. Peer support training may be particularly effective: we know young people more often talk to each other about personal problems rather than an adult (Sharp, et al., 2008). Talking about these issues will increase teacher and student awareness of suicidal behaviour risk factors.

Within school, we know that students are often resistant to asking for help. Worries about confidentiality are among the main reasons for this resistance. There is still a long way to go to overcome the stigma attached to talking about emotional and mental health. Talking more openly about suicidal behaviour is, I believe, a first step in helping. (The SOS evaluation mentioned above found that 'asking for help' was the one feature of its programme that did not change student behaviour.)

Evaluating the effectiveness of prevention programmes has produced some contradictory conclusions. Some clear indications of success come from the SOS programme. Further successful indications have been seen when there is parental involvement and where students are screened for depression or suicidal ideation so that further help can be offered.

Conclusion

The risk factors associated with suicidal behaviour are complex. The growing importance given to exams in many countries is well documented, although making direct links between these developments and suicidal behaviour is not always easy. There are clear indications however, that the pressure to perform in an increasingly micro-managed, accountable education system may be playing a part in developing mental health problems and in suicidal behaviour.

More research should be done on this issue. School programmes which offer help should identify exams and school performance as contributory indicators of stress and suicidal behaviour. Advising students on coping skills as part of these programmes is becoming increasingly necessary.

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