A Psychological Autopsy of the Suicide of an Academically Gifted Student: Researchers’ and Parents’ Perspectives

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ABSTRACT

This study uses the methods and procedures of psychological autopsy to portray the life of an academically gifted college student who completed suicide. The study is unique in that it follows the subject across his 21 years of life, highlighting relevant milestones and significant stages and events. A comprehensive view of the life and death of a gifted student is offered through both researchers’ and parents’ perspectives, along with multiple theoretical explanations, including a developmental explanation.

This psychological autopsy yielded three sets of findings: those that reflected exclusively on the subject’s life, those that compare his life with 3 previous psychological autopsies conducted, and those that reflect the parents’ observations and experiences of his life. Two important findings of this study include a depiction of the psychological makeup of a subject in interaction with his environment and the fact that many of the factors contributing to suicidal behavior identified for the general population of adolescents and young adults existed in this case, as well. Consequently, as Cross, Cook, and Dixon (1996) found, certain types of aberrant behavior, belief systems, or both should not be considered a typical part of being a gifted person; they should be recognized as potential indicators of suicidal behavior.

Few things are more disturbing than the death of a child. Even more upsetting is the death of a child by his or her own hand. An unfortunate characteristic of American culture since 1950 has been the increasing number of its population that completes suicide. For example, in 1990, 30,906 people completed suicide in the United States (Holinger, Offer, Barter, & Bell, 1994). In addition, steady increases in completed suicides have been documented over the past 4 decades in virtually every age group (0–14, 15–24, 25–40, 41–55, 56–70, and more than 70) studied. While the 15–24-year-olds (adolescents and young adults) ranked third in 1994 among all age groups in the total number of suicides (4,869), they ranked second lowest in rate of suicide (a calculation per 100,000 people) among all age groups (Holinger et al.).

Suicide of Adolescents and Young Adults

The incidence of suicide has grown dramatically since 1955 and is now considered the second leading cause of death among adolescents and young adults (Capuzzi & Golden, 1988; Felner, Adan, & Silverman, 1992; Vital...
Statistics, 1986). In addition, historical patterns appear in the study of suicide among the 15- to 24-year-old age group. Higher rates of suicide were observed in the 1930s (the Great Depression), lower rates in the 1940s (World War II), and steady growth rates from the 1950s to the present. Cross-cultural data concerning the incidence of suicide shows a drastic increase from the ages of 5-14 to 15-24 (Holinger et al., 1994). In addition, gender effects appear cross-culturally, for males have a higher rate of completed suicide at nearly every age level (Holinger et al.).

Hidden within the overall group of adolescents are subgroups with a higher rate of suicide than the average rate for the entire group. For example, the most startling estimates of subgroups of adolescents were forwarded by Alessi, McManus, Brickman, and Grapentine (1984), who found that 61% of juvenile defenders attempted suicide, and Tomlinson-Keasey and Keasey (1988), who estimated that 33% of troubled adolescents in their study attempted suicide. From these and other studies we can conclude that the rate of adolescent suicide has risen over the past 4 decades, as have the rates of other groups. We can also conclude that subgroups within the adolescent and young adult group vary in their rate of suicide.

The field of suicidology has made considerable strides in determining the rates of suicide among differing groups of people, researching the salient events and circumstances surrounding suicide, as well as the cataloging of characteristics shared by the victims of suicide. As evidence to this claim, Hollinger and Offer (1981) noted that the literature base on suicide doubled from 1969 to 1980. One of the most important contributions of previous research on adolescent suicide has been the determination that there are significant risk factors (see Table 1).

Epidemiological research suggests that males have a higher rate of completed suicide at nearly every age level (Holinger et al., 1994). Individuals are considered at-risk for suicide when they present a variety of risk factors and begin thinking about or planning on taking their own lives. Salient risk factors related to suicide include psychiatric disorders; family relations; family history of psychiatric disorders, suicide, or both; abuse of drugs, alcohol, or both; environmental stresses; exposure to other attempts; social isolation; homosexuality; prior suicidal behavior; and firearms present within the home (Dixon & Scheckel, 1996; Holinger et al.).

Schuckit and Schuckit (1991) examined substance use and abuse as a risk factor in adolescent suicide. Controlled substances, alcohol, or both are frequently used as the means of self-harm or as a prelude to a suicidal act, contributing to reduced inhibitions, increased impulsivity, and impaired judgment. Socioeconomic factors associated with high risk of suicide include exposure to high levels of stress, especially at an early age (Pfeffer, 1991). Such stresses include loss of social supports through death, parental separation or divorce, change in school environments, and problems with peer relationships.

Holinger et al. (1994) reviewed retrospective and prospective research on suicide and found that most individuals who kill themselves meet criteria for diagnosable psychiatric disorders, including affective disorders (25-75%), personality disorders (25-40%), or both. The diagnoses in these cases were, however, made after the suicide. In fact, one study reported that “only 24% of completed suicides (male and female, all ages) had been in contact with mental health services within the past two years” (Appleby, 1999, p. 3). The comorbidity of affective disorders, personality disorders, substance abuse, or some combination of these two factors appears to be particularly lethal. Approximately 25-50% of adolescents completing suicide have a family history of psychiatric disorders, suicides, or both, and 25-50% have previously attempted to take their own lives. The number and lethality of attempts were also found to correlate positively with completed suicide. In addition, when firearms were found within the home, a marked increase in the risk of suicide was observed. Sexual identity issues, such as homosexuality, also increased the risk of suicide among adolescents. Research (Sargent, 1984; Shaffer, 1974) has indicated that suicide completers tend to be brighter than average.

A variety of psychologists proposed alternative theories about why adolescence is a time of contemplation of

Table 1

Significant Risk Factors Associated With Adolescent Suicide

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Psychiatric disorders such as depression and anxiety.</td>
</tr>
<tr>
<td>2</td>
<td>Drug and alcohol abuse.</td>
</tr>
<tr>
<td>3</td>
<td>Genetic factors.</td>
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<td>4</td>
<td>Family loss or disruption.</td>
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<td>5</td>
<td>Friend or family member of suicide victim.</td>
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<tr>
<td>6</td>
<td>Homosexuality.</td>
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<td>7</td>
<td>Rapid socio-cultural change.</td>
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<tr>
<td>8</td>
<td>Media emphasis on suicide.</td>
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<tr>
<td>9</td>
<td>Impulsiveness and aggressiveness.</td>
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<tr>
<td>10</td>
<td>Ready access to lethal methods.</td>
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</table>

suicide for some. First and foremost, suicide has been linked to the presence of depression. For individuals who are depressed, suicide may be seen as a viable option. For example, Golombek (Sargent, 1984) studied the relationship of depression, risk of suicide, and personality in what he identified as three stages of adolescence. According to Sargent (1984), Golombek theorized that

Depression is expressed differently in each of three stages of adolescence. In early adolescence, depression may be manifested by anger and disorganized or erratic behavior. In mid-adolescence, a stage of rebellion, depression may be seen in exaggerated autonomy and angry outbursts. Later adolescence brings a “new sense of separateness,” with disillusionment, dissatisfaction, and a sense of loss. During this period, depression is more typically expressed by feelings of sadness and guilt and is more self-directed. (p. 50)

Therefore, Golombek viewed late adolescence as the time that suicide could most likely result from depression, thereby explaining the increased incidence of suicide at this stage of development.

Shneidman (1981) discussed four elements of suicide: (a) heightened inimicality, (b) exacerbation of perturbation, (c) increased constrictional intellectual focus (tunneling or narrowing of the mind’s content), and (d) cessation. Inimicality involves “qualities within the individual that are unfriendly toward the self” (p. 222), or ways in which the individual is his or her own enemy, such as engaging in self-destructive behaviors. According to Shneidman, perturbation refers to “how disturbed, ‘shook up,’ ill at ease, or mentally upset a person is” (p. 223). Dichotomous thinking, blocking out memories of the past, or avoiding thought about how others would be affected are examples of constriction. Shneidman identified the concept of cessation as the spark that ignites the above potentially explosive mixture. Cessation involves the idea that one can put a stop to his or her pain, thereby producing a perceived solution for the desperate individual.

Psychodynamic explanations, such as Freud’s, have viewed suicide as internal conflict of aggression turned upon one’s self (Grollman, 1971; Stillion & McDowell, 1996). A suicide attempt may also be the expression of aggression against an internalized object (Shneidman, 1981). A more contemporary psychodynamic theory of suicide is that adolescents who complete suicide escape conflict and stress (Holmes, 1991). Evidence of the influence stress can have on the incidence of suicide includes the historical patterns apparent in the field of suicidology. For example, higher rates of suicide were observed during the Great Depression, a time of great stress.

Humanistic theories purport that, “provided basic needs are met, humans are essentially growth-oriented creatures whose nature is directed toward realizing their potential if external conditions permit” (Stillion & McDowell, 1996, p. 58). Therefore, suicidal adolescents may have difficulty fulfilling their basic needs. Existential theory focuses on the difficulty individuals can have in finding meaning in their lives. Inability to discover meaning in life can also lead to feelings of uselessness, hopelessness, and depression. These feelings can, in turn, lead to suicide (Frankl, 1963).

One cognitive explanation for suicide suggests that, when adolescents lack adequate problem-solving skills and face stress-provoking problems, they develop an attitude of hopelessness and eventually attempt suicide because they see no other alternative. Holmes (1991) described this process as follows: An inability to solve their problems can lead adolescents to feelings of hopelessness, which can be closely related to suicide. Once cognitively rigid adolescents decide on suicide as a solution to their problems, they will pursue only that solution and not consider or develop alternative solutions.

Stillion and McDowell (1996) integrated many of the above theories in their Suicide Trajectory Model, which includes four main categories of risk factors that should be examined when working with suicidal adolescents: biological (e.g., depression, genetic factors, male gender), psychological (e.g., depression, low self-esteem, hopelessness, existential issues, poor coping strategies), cognitive (e.g., developmental level, negative self-talk, cognitive rigidity, generalization, selective abstraction, inexact labeling), and environmental (e.g., negative family experiences, negative life events, loss, presence of firearms). Along with influencing the occurrence of suicide among adolescents, these risk factors may also influence each other. For example, an adolescent who has encountered negative family experiences may, in turn, have poor coping strategies. Stillion and McDowell described the influence of the factors identified in their model of suicidal ideation, gestures, and attempts in adolescents.

As we move through life, we encounter situations and events that add their weight to each risk factor category. When the combined weight of these risk factors reaches the point where coping skills are threatened with collapse, suicidal ideation is born. Once present, suicidal ideation seems to feed upon itself. It may be exhibited in warning signs and may be intensified by trigger events. In the final analysis, however, when the suicide attempt is made, it occurs because of the contributions of the four risk categories. (p. 21)

Therefore, according to these authors’ views, understanding suicide among adolescents involves understanding the life experiences related to each of the above risk factors and how they contribute to the decision to attempt suicide.
Table 2

Reasons Few Studies Have Been Conducted on the Suicides of Gifted Students

1. The current data collected nationally about adolescent suicide does not include if the child was gifted.
2. The varying definitions of gifted and talented used across the United States make it difficult to know if a child who completed suicide was gifted.
3. Issues of confidentiality limit access to data.
4. Conducting psychological autopsies of suicide victims is an expensive endeavor in terms of time and money.
5. Conducting research on this topic is more difficult because more adolescent-aged students than preadolescents complete suicide, combined with the fact that secondary schools, colleges, and universities are not as actively engaged in identifying gifted students.
6. The terminal nature of suicide requires certain types of information to be garnered after the event.


Suicide of Gifted Adolescents and Young Adults

Given our ability to estimate the rate of suicide among the general population of people from 15–24 years of age, what do we know about the suicides of gifted adolescents and young adults? Unfortunately, there is a paucity of research on the suicidal behavior of this group (Cross, 1996; Cross, Cook, & Dixon, 1996). Table 2 includes six reasons that there have been few studies conducted on the suicides of gifted students.

Dixon and Scheckel (1996) summarized current thinking about the characteristics of gifted adolescents often associated with risk of suicide. They include perfectionism (Blatt, 1995), isolationism to extreme introversion (Kaiser & Berndt, 1985), unusual sensitivity and perfectionism (Delisle, 1986), and the five overexcitabilities (psychomotor, sensual, intellectual, imaginative, and emotional) identified by Dabrowski as part of his Theory of Positive Disintegration and elaborated on by Piechowski (1979).

Other authors have discussed suicide and gifted students through the lens of humanistic psychology. These authors (e.g., Roeper & Willings, 1984; Webb, Meckstroth, & Tolan, 1982) have discussed the characteristics and tendencies that they believe put gifted students at risk for suicidal behaviors. Delisle (1982), after having reviewed the literature base, listed lack of friendships, self-deprecation, sudden shift in school performance, total absorption in school work, and frequent mood shifts as possible warning signs of suicidal behavior among gifted students. Although these articles are informative, they are strictly theoretical, not empirical.

Another subset of the literature base is made up largely of epidemiological studies concerned with incidents of attempted suicide and completed suicide (Cross, 1996). Hayes and Sloat (1990) investigated the prevalence of suicide among gifted students across 69 schools in a four-county region. They found that 8 of the 42 cases of attempted suicide were among gifted students, but none actually died by suicide.

Parker and Adkins (1995) found that students in honors colleges demonstrated significantly higher scores on subscales of an instrument measuring perfectionism. They questioned whether elevated perfectionism is indicative of a “predisposition to maladjustment or is a healthy component of the pursuit of academic excellence among the highly able” (p. 303).

Two studies (Tomlinson-Keasy & Warren, 1987; Tomlinson-Keasy, Warren, & Elliot, 1986) drew on longitudinal data from the Terman sample focusing on the suicides of females. Discriminant function analyses were performed in both studies, yielding “signatures of suicide.” The signatures included in the analysis—previous suicide attempts, anxiety, depression, temperament, mental health, loss of a father before age 20, stress in the family of origin, physical health, and alcohol abuse—correctly classified 37 of 40 participants. These signatures inform the knowledge base about gifted adult females of a certain generation who were determined to be gifted using Terman’s notion of giftedness from the 1920s. Given that most suicides are males, plus the fact that the steady increase in suicides began in the 1950s, the signatures may have limited explanatory power in this study.

According to Cross (1996), the following can be said about the suicide of gifted adolescents.

1. Adolescents are committing suicide; therefore, gifted adolescents are committing suicide.
2. The rate of suicide has increased over the past [4] decade[s] for the general population of adolescents within the context of an overall increase across all age groups; therefore, it is reasonable to conclude that the incidence of suicide among gifted adolescents has increased over the past decade, keeping in mind that there are no definitive data available on the subject.
3. Given the limited data available, we cannot ascertain whether the incidence of suicide among gifted adolescents is different than in the general population of adolescents. (pp. 47–48)

While establishing incidence rates of suicide and describing the factors associated with suicide among gifted adolescents are important, another important goal of suicidology is to describe the lives of suicide victims (Cross,
Cook, & Dixon, 1996). To that end, a variety of case studies of gifted students have been carried out in an attempt to shed light on the suicidal behavior of the subjects (Johnson, 1994; Peterson, 1993). One of the most promising approaches to studying the lives of gifted adolescents who have completed suicide is the psychological autopsy (Cook, Cross, & Gust, 1996; Cross et al.).

Three psychological autopsies of gifted adolescents were conducted in a previous study (Cross et al., 1996). Because of the similarities of the subjects in that study with the subject in this study, the results and conclusions of the previous study are presented later in this article. The Cross et al. study yielded two important findings. The first was that the emotional characteristics, relational factors, and behavior problems of the three gifted adolescents who completed suicide were consistent with the patterns of suicides of general adolescents. A second important finding revealed that factors in the three case studies were consistent with theories of and research on gifted adolescents.

The current study compares its findings with those of the three case studies of Cross, Cook, and Dixon (1996). The researchers believe that building a significant number of case studies within the research base on suicidal behavior of gifted students will eventually answer the questions of why gifted students complete suicide and what we can do to prevent it. In addition, various risk factors and theories of suicide are applied to this case study to provide greater understanding of factors contributing to the suicide of gifted individuals.

Rather than classifying the subject a priori as a casualty of a psychological malady, this study uses a phenomenological lens to examine his life. Following the Results section, several prominent psychological theories are used to explain the suicide. The parents of the subject comment on the degree to which each of the theories accurately reflects their observations of the subject across his 21 years. A partial inventory of risk factors is also included.

Subject

Reed Ball, the subject of this study, was a 21-year-old academically gifted college student living in Calgary, Alberta, Canada. He completed suicide in 1994. An American, Reed was born in Omaha, Nebraska, but lived in Canada much of his life. He was the younger of two sons in an intact family with both parents being professionals. He became a subject in this study after his parents read the article previously noted (Cross et al., 1996) and contacted the first author about the possibility of studying Reed’s life. The initial contact was made in 1997, and data was collected through 2001.

Psychological Autopsy

The data-gathering approach used in this study is called psychological autopsy. Ebert (1987) described psychological autopsy (PA) as a process designed to assess a variety of factors, including behaviors, thoughts, feelings, and relationships, of an individual who is deceased. It was developed originally as a means of resolving equivocal deaths. The PA has expanded to include the analysis of nonequivocal suicides, with the intention of reducing their likelihood in similar populations (Jones, 1977; Neill, Benensohn, Farber, & Resnick, 1974). It can be used as a posthumous evaluation of mental, social, and environmental influences on the suicide victim. Because psychological autopsies enable researchers to investigate the lives of deceased subjects in an effort to reduce the likelihood of suicide among similar groups of individuals, it was chosen as the research approach for this study.

This psychological autopsy utilized two broad categories of information: (a) interviews with people with whom the victim had significant relationships (e.g., parents) and (b) archival information related to the victim (e.g., school records, test information, medical records, personal letters, essays, diaries, suicide notes, artwork, and reports from authorities). The researchers analyzed the information collected to identify themes and issues that may be valuable in the prediction of suicide within similar populations.
The study was conducted over a 4-year period from 1997 through 2001. Interviews with parents and the Reed documents, letters, and records were analyzed and are reported in the Appendix, providing a developmental history of milestones and significant events across Reed’s life. The source of the information is indicated beside each summary statement. For example, when the summary statement states “notes” and “from parents,” this information was obtained from the parents through notes they had written at that time in Reed’s life. When the statement indicated “from Reed,” the information was gathered from Reed’s own writing. The parents reviewed the information in the Appendix, providing a member-checking opportunity for the researchers. The parents provided fact checking and also challenged or corroborated meanings drawn or interpretations made by the researchers. Parents also provided their own observations and experiences for each milestone or event recorded in the Appendix. The researchers and parents believe that the two sets of voices provide a substantial depiction of the subject across his 21 years.

Results

The Appendix provides a timeline of significant events across the life of the subject, and Table 3 provides the themes observed from Reed’s case history. Consistent with adolescent and young adult suicide in the general population, Reed was a Caucasian male who manifested four emotional characteristics: depression, anger (represented more in suppressed rage and frustration than physical actions), mood swings, and confusion about the future, while demonstrating poor impulse control (manifested more often in patterns of thought than in behavior). He experienced three relational commonalities with those in the general population who complete suicide: romantic relationship difficulties, self-esteem difficulties (either by exaggeration or self-condemnation), and isolation from persons capable of disconfirming irrational logic. Reed shared warning signs in several categories: behavior problems, period of escalation of problems, constriction, withdrawal from friends, dichotomous thinking, talking about suicide, and erratic school performance.

When comparing this case study to the previous three case studies by Cross, Cook, and Dixon, (1996), the following similarities were found:

1. All four subjects exhibited overexcitabilities. Their overexcitabilities were expressed in ways or levels beyond the norm even among their gifted peers. The

<table>
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<th>Table 3</th>
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<td><strong>Themes Observed From Case History</strong></td>
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<tr>
<td>1. History of mood swings starting at 7 years old.</td>
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<tr>
<td>2. Periods of extreme depression/hopelessness and impaired judgment.</td>
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<tr>
<td>3. Difficulty adjusting to move to new school/country.</td>
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<td>4. Interpersonal difficulties with peers, including romantic relationships.</td>
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<td>5. Low self-esteem.</td>
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<tr>
<td>7. Suicidal ideation present for 8 or more years and over 12 attempts at self-harm.</td>
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<tr>
<td>8. Felt a loss of control, impairment of judgment, and lost trace of reality prior to final attempt (some psychotic features present).</td>
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four subjects had minimal prosocial outlets. All four subjects experienced difficulty separating fact from fiction, especially overidentification with negative, asocial, or aggressive characters or themes in books and movies. They experienced intense emotions, felt conflicted, pained, and confused. All four subjects devalued emotional experience and wanted to rid themselves of emotions.

2. Each of the young men expressed polarized, hierarchical, egocentric value systems.

3. They each engaged in group discussions of suicide as a viable and honorable solution.

4. Additionally, all four subjects expressed behaviors consistent with Dabrowski’s Level II or Level III of Positive Disintegration.

These similarities are striking in their consistency. The parents confirmed Reed’s similarity to the three other case studies: “This last analysis so clearly describes Reed, it is quite scary. We only wish we all had figured it out before Reed died.”

Discussion

To enhance the level of explanatory power of the suicide, the researchers drew on major theories in psychology to consider the data collected. It is believed that none of the theories provide complete explanatory power, but all offer insight into Reed’s suicidal behavior. His parents provided their assessment of the degree to which each theory captures their experiences with and observations of Reed. Table 4 provides a brief analysis of aspects of the
### Various Theories Applied to Case Study

<table>
<thead>
<tr>
<th>Golembek’s Theory</th>
<th>Shneidman’s Theory</th>
<th>Psychodynamic Theory</th>
<th>Existential Theory</th>
<th>Cognitive Theory</th>
<th>Suicide Trajectory Model</th>
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<tbody>
<tr>
<td>Periods of depression present starting age 7</td>
<td>Inimicality: Withdrawal from others, dishonesty with others versus 100% honesty with himself, and attachment to others when feelings were not mutual or on the same level</td>
<td>Engaged in a variety of escapist behaviors, including his early interest in fire, self-analysis, and withdrawal from others</td>
<td>Attempted to find meaning in his relationships with others</td>
<td>The difficulty he experienced in developing intimate interpersonal relationships (and problem solving) contributed to his feelings of hopelessness and the belief that he would hurt others if he allowed them to become too close to him.</td>
<td>Biological factors: depression, genetic factors, male gender</td>
</tr>
<tr>
<td>Late adolescence is a time of increased withdrawal</td>
<td>Perturbation: October 1992 fears losing control, lost trace of reality (experiencing memories of events that did not happen), and concern about what he might do to others if not in complete control</td>
<td>During 11th grade, he noted on a paper that “reality is not pleasant”—used various ways to escape his situation, ultimately taking his own life</td>
<td>His relationships did not include the level of intimacy Reed desired, leaving him feeling disillusioned and alone, adding to his depression</td>
<td>Cognitive rigidity—experienced suicidal ideation since age 13 and made over 12 attempts at ending his own life—became extremely focused on this solution, not looking for or discounting other possibilities.</td>
<td>Psychological factors: depression, low self-esteem, hopelessness, existential issues, poor coping strategies</td>
</tr>
<tr>
<td>Late adolescence feelings of sadness and guilt became more self-directed</td>
<td>Increased constriction of intellectual focus: Dichotomous thinking, blocking out memories of the past, and avoiding how others would be affected by death</td>
<td>Cessation: He believed he could put a stop to his pain through his death.</td>
<td></td>
<td></td>
<td>Cognitive factors: negative self-talk, cognitive rigidity</td>
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<td></td>
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<td></td>
<td>Environmental factors: negative life events (e.g., harassment by peers)</td>
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salient information from the vantage point of multiple theories, and Table 5 highlights various risk factors applied to this case study.

Psychological Theories of Suicide Applied to Case Study

Golombek’s Theory

Suicide has been clearly linked to the presence of depression. For Reed, periods of depression were present starting at age 7; such periods were apparent in parent notes of Reed’s feelings of “crabbiness,” missing schoolwork, and withdrawal from others. Reed’s mood shifted from depression to more manic periods. It was during his more depressed periods that he viewed suicide as a viable option to escape his feelings of isolation and pain.

Parents: It is important to note two things. First, Reed started these mood swings so early that we all (parents, teachers, friends) just took them as part of Reed’s personality. Second, Reed was “high functioning”—his manic periods appeared no more than Reed “finally getting his act together and working to potential,” his depressive periods just the result of “normal” school bullying, etc. This was also 1975–1985, before Childhood Depression was widely known. In fact, when we talked to his Omaha pediatrician about Reed’s mood swings, the doctor did note the possibility of a minimal brain dysfunction on Reed’s records. No one ever connected it with Reed’s later behavior, however, nor were they particularly interested in this early observation.

Reed’s behavior in early and mid-adolescence appears to be explained by Golombek’s theory concerning depression in early adolescence: “depression may be manifested by anger and disorganized or erratic behavior. In mid-adolescence, a stage of rebellion, depression may be seen in exaggerated autonomy and angry outbursts” (Sargent, 1984, p. 50).

According to Golombek, late adolescence is the time that suicide could most likely result from depression. For Reed, late adolescence was a time of increased withdrawal from others. For instance, parent notes from grade 12 indicate that Reed was “withdrawn . . . wants to be last . . . did faint in class one month ago . . . looks tired.” Reed indicated in his suicide note in September 1992 that suicidal ideation began around age 13 (eighth grade). During the period of late adolescence, his feelings of sadness and guilt clearly became more self-directed, resulting in his completed suicide in early adulthood.

<table>
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<th>Table 5</th>
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<td>Various Risk Factors Applied to Case Study</td>
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<tr>
<td><strong>Personal Factors</strong></td>
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<tr>
<td>Male gender</td>
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<tr>
<td>Psychiatric disorder (bipolar with psychotic features)</td>
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<tr>
<td>No diagnosis ever attempted. Referral never suggested by anyone—school/university, physician, church, friends, etc.</td>
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<tr>
<td>Drug and/or alcohol abuse</td>
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<tr>
<td>Friends say Reed rarely drank, but there are stories of a few attempts to get drunk. Reed said he didn’t like the taste, so getting drunk had no appeal. The suicide was an overdose of over-the-counter sleeping pills; the autopsy showed a blood alcohol of 0.0.</td>
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<tr>
<td>Sexual identity issues</td>
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<td>Family/Friends all say no; neither the autopsy nor the stuff Reed left behind showed evidence of homosexual activity/interest.</td>
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<tr>
<td>Higher intelligence</td>
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<td>WISC-R score: 99th percentile</td>
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<tr>
<td>Family history of psychiatric disorders and/or suicide</td>
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<tr>
<td>Environmental Factors</td>
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<tr>
<td>Loss of social support through death</td>
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<td>Parental separation or divorce</td>
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<tr>
<td>Change in school environments</td>
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<tr>
<td>Problems with peer relationships</td>
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<tr>
<td>Social isolation</td>
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<tr>
<td>Poor family relations</td>
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<tr>
<td>Firearms present within the home</td>
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<tr>
<td>Prior Suicidal Behavior</td>
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<tr>
<td>Multiple attempts</td>
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<tr>
<td>Lethal attempts</td>
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<td>Exposure to the attempts of others</td>
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Parents: Reed doesn’t fit the profile here. He was not an “angry” person—grumpy, manipulative, for sure. He often felt bullied and that everybody was his “enemy,” but he wasn’t “angry.” Perhaps because Reed’s depressive cycles started so early he was well past “angry” by the time he got to his teens. As someone said, “Murder is anger turned outward, suicide is anger turned inward.”
Shneidman’s Theory

Heightened iminimality, one of the four elements of suicide described in Shneidman’s (1981) theory, involves “qualities within the individual that are unfriendly toward the self” (p. 222). This includes self-destructive behaviors. For Reed, this involved his withdrawal from others, his dishonesty with others versus the honesty he had with himself, and his attachment to others when feelings were not mutual or on the same level.

Parents: Reed’s suicide note is so telling here: “By the time I had gotten to high school, I was spending an average of 2 hours each day analyzing myself—usually looking at what the day had brought; and what I had done; and how I could do it differently, better. Plus, I always had some old mistakes that I had made that I wanted to find solutions for in case similar situations came up again.”

According to Shneidman (1981), perturbation, another element of suicide described in his theory, refers to “how disturbed, ‘shook up,’ ill at ease, or mentally upset a person is” (p. 223). In October 1992, Reed wrote to a friend of his fear of losing control, his lost trace of reality (experiencing memories of events that did not happen), and his concern about what he might do to others if not in complete control, all illustrating perturbation.

Another element of Shneidman’s theory, constriction, was evident in Reed’s behavior in the form of dichotomous thinking, blocking out memories of the past, or avoiding thoughts about how others would be affected. It was especially clear that Reed blocked out thoughts of how his family would be greatly affected by his death.

Parents: From our perspective, his not thinking of the impact of his suicide on us was/is the “normal” path of suicide—folks about to complete suicide go into a “tunnel” and don’t hear/feel the love and caring of those about them. An example would be from his suicide note:

“At some point; I’m not quite sure when though; I noticed something. Through all of my introspection, I had managed to develop a rigid code of ethics to live and act by. I think it may have come out of pride; if I were the best, then I should be able to find solutions to manipulation that were undetectable to others. And then that didn’t harm others; and finally; that helped others; and even then; only those who wanted to be helped. An ego-centered person; I was so full of myself that I felt I should be able to achieve results without hurting people; or affecting those who didn’t want to be.”

I remember him telling me about this “code of ethics” when he was in high school and having the uneasy feeling that, while they sounded “high-minded,” they were manipulative. Something wasn’t quite right. There is also the more “generic” observation here that Reed’s lifelong coping strategy was avoidance/escapism. Rather than facing the hard work in whatever, he would back away and decide he didn’t want to do that anymore.

Rather than thinking of the effect of his death on others, Reed focused on his fear of hurting others through his behaviors if he continued living. Cessation involves the idea that one can put a stop to his pain, thereby producing a perceived solution for the desperate individual. Reed’s suicide notes made reference to his desire to escape the pain he was experiencing. In addition, he engaged in various escapist behaviors in his life (e.g., withdrawal from others, self-analysis) that also contributed to his pattern of escaping painful aspects of his life.

Psychodynamic Theory

Reed’s behavior certainly fits within psychodynamic explanations of suicide as internal conflict or aggression turned upon one’s self (Grollman, 1971; Stillion & McDowell, 1996) or the expression of aggression against an internalized object (Shneidman, 1981). A more contemporary psychodynamic theory of suicide is that individuals who complete suicide escape conflict and stress (Holmes, 1991). As mentioned earlier, Reed engaged in a variety of escapist behaviors, including early interest in fire, self-analysis, and withdrawal from others. In his “Dream Paper” from the 11th grade, Reed noted “reality is not pleasant.” Therefore, he used various ways to escape his situation, ultimately resulting in taking his own life.

Existential Theory

Existential theory (e.g., Frankl, 1963) focuses on the difficulty individuals can have in finding meaning in their lives. Inability to discover meaning in life can also lead to feelings of uselessness, hopelessness, and depression. These feelings can, in turn, lead to suicide. Reed attempted to find meaning in his relationships with others. However, these relationships did not include the level of intimacy Reed desired, leaving him feeling disillusioned and alone, adding to his depression.

Parents: While we agree that Reed struggled with discovering the “meaning of life,” we come to it from a different perspective. First, finding the “meaning in life” seemed to be far more important to Reed than most people—Dabowski’s “overexcitabilities” perhaps?
For a long time, we struggled with the analysis that “problem with relationships” was Reed’s “problem.” Reed, by both his definition and ours, had many good friends; actually far more really good, long-term friends than the rest of our family can claim. Young and old liked Reed! And Reed cared about his friends. In fact, that may be why we missed the fact that he did, indeed, struggle with “relationships”—specifically with [female] “kindred spirit” and/or romantic relationships. Our family [are] basically introverts. We have friends, but we “live” in our heads, rather than hearts. We enjoy peers at work and committees, we care for our friends, but have little need to “socialize.” So, it wasn’t until I happened to be talking to Dr. Sal Mendaglio one day that the penny dropped. Dr. Mendaglio’s notion is [that it is] whether a person “needs” friends that makes a difference. Or, as stated above, Reed needed to find meaning in his relationships with others and, by his measure, was unsuccessful in doing that.

A key loss that also needs mentioning is Reed’s loss of his core identity as a “math whiz” when he went to university. This had been a key component of Reed’s identity since he was 3, and it wasn’t without foundation. He’d learned to play Monopoly at age 3 (and beat us!). We had to send 3-year-old Reed out of the room when we were doing math flash cards with his 5-year-old brother; he was 32nd in the national [Canadian] grade-10 math competition. So, it’s not surprising that he went into a tailspin when he went to university and abruptly discovered that “mathematics” (his dream) wasn’t what he expected and, to add insult to injury, was met with total disinterest when he attempted to talk to the mathematics department about his vision. We had tried to broaden his horizons along the way and again when the university math dream fell apart, but were never successful.

Cognitive Theory

According to one cognitive explanation for suicide, adolescents who lack adequate problem-solving skills and face stress-provoking problems develop an attitude of hopelessness and eventually attempt suicide because they see no alternative. An inability to solve problems can lead to feelings of hopelessness, which can be closely related to suicide. For Reed, the difficulty experienced in developing intimate interpersonal relationships contributed to his feelings of hopelessness and the belief that he would hurt others if he allowed them to become too close to him.

Parents: It took us a long time after Reed died to correlate this theory to Reed, for, from many perspectives, Reed had excellent problem-solving skills! He loved to play highly complex computer role-playing games. He and his dad loved to tackle logic puzzles. He loved to play chess and did amazing things with computers. He successfully, if creatively, dealt with life’s daily struggles (I missed the bus, now what do I do?). It wasn’t till long after Reed died that I realized that, when psychologists talk about “problem-solving skills,” they are talking about interpersonal problem solving and, perhaps adapting to change/trauma (like the move from Omaha).

Once adolescents or young adults who are cognitively rigid decide on suicide as a solution to their problems, they will pursue only that solution and not consider or develop alternative solutions. This was apparent with Reed. He noted experiencing suicidal ideation since age 13 and making over 12 attempts at ending his own life. He became extremely focused on this solution, discounting or not looking at other possibilities such as psychotherapy for easing his pain.

Parents: Absolutely. I remember the three of us talking at Reed’s memorial service about how Reed’s suicide was a “self-fulfilling prophecy.” It was like a train roaring down a mountainside out of control. We could see it happening, but couldn’t figure out the “brilliant intervention” to stop it.

Reed did not believe that his situation could improve, noting his belief that he was losing control of his behavior. The role that hopelessness plays in suicide was demonstrated in a study (Beck, Steer, Kovacs, & Garrison, 1985) in which inpatients were administered a hopelessness scale and followed to determine which ones had attempted suicide. Of the 14 patients who had attempted suicide, 13 had high scores on this scale. Hopelessness was present in Reed, as well.

Parents: Exactly. There is no more eloquent comment than Reed’s own words in his suicide note: “I’ve taken away from myself the one thing I hold most dear. My freedom.

“While physically I’m not restrained; mentally I no longer have free will; and this binds me as much as chains and bars would. Everything I try to do automatically gets analyzed over and over by what my past has dictated is the best way. Every decision I make I know why I made it—even ones made in reaction to something back when I don’t have time to think up front. Even the wrong decisions I know why I made them. And I know why my mind is set up to make those decisions. And the worst part about it is that the whole mess is a trap. Each ‘wrong’ decision is ‘right’ by some reason; and I am forced to accept that. I can’t even fix the problem; because even though I could get rid of all this decision-making machinery of mind with the help of a good psychologist; there’s one further problem.

“I’ve become the machinery. To destroy it would be to destroy me . . . and I can’t live while I’m broken.”
Furthermore, according to cognitive explanations, suicide can stem from two different classes of cognitions: (a) normal cognitions involving reduced problem-solving skills and hopelessness and (b) abnormal cognitions involving delusions and hallucinations (Holmes, 1991). It appears that, during the early stages of his suicidal ideation, Reed experienced normal cognitions involving reduced problem-solving skills and hopelessness. However, closer to his final attempt at self-harm, Reed began experiencing, as he noted, a “lost trace of reality,” including memories of events that did not occur and reduced ability to control his actions.

Parents: Probably true. On the other hand, his long time girl-buddy told us that, the week before Reed suicided, he’d taken her out to dinner. They’d had a wonderful time, just like always. Neither she (nor other friends) had seen anything out of the ordinary—even after they became aware of the much touted “suicide warning signs.” Our common analysis is that Reed had lived with depression for so long that he’d learned to “put on a happy face.” And we, on the other hand, had just accepted all the funny little bits—they were just part of “Reed.”

Suicide Trajectory Model

The risk factors described in Stillion and McDowell’s (1996) Suicide Trajectory Model can be identified in Reed’s case. For Reed, these included biological (depression, genetic factors, male gender), psychological (depression, low self-esteem, hopelessness, existential issues, poor coping strategies), cognitive (negative self-talk, cognitive rigidity), and environmental (negative life events) risk factors, which may also have influenced each other. For example, the negative life events (e.g., harassment by peers) experienced by Reed might have, in turn, contributed to his poor coping strategies, especially his concern about expressing his feelings to others.

According to Stillion and McDowell (1996), understanding Reed’s suicide involves understanding the life experiences related to each of his risk factors and how they contributed to his decision to attempt suicide. Over time, the combined weight of the risk factors contributed to Reed’s increased suicidal ideation, gesturing, and final attempt.

Dabrowski’s Theory of Positive Disintegration (TPD)

Dabrowski’s (1964) Theory of Positive Disintegration (TPD) describes the characteristics that make up a person’s Developmental Potential (DP). TPD includes five levels representing a continuum of emotional development from egocentric to altruistic. Piechowski (1999) characterized the hierarchy of levels as follows: I—Primary Integration, II—Unlevel Disintegration, III—Spontaneous Multilevel Disintegration, IV—Organized Multilevel Disintegration, and V—Secondary Integration. To move from one level to the next requires that lower order cognitive-emotional structures be replaced by higher order ones. Dabrowski called this process positive disintegration. Not everyone develops to the highest levels, however, and the TPD attempts to articulate factors of DP.

According to Dabrowski, DP is a function of heredity/environment, psychic overexcitabilities, and dynamisms and is an indication of a person’s capacity to move up the five levels of development. The five overexcitabilities are considered ways of experiencing the world. Psychic overexcitabilities include psychomoter, sensual, intellectual, imaginative, and emotional. Overexcitabilities are thought of as enhanced modes of being in the world (Piechowski, 1999). Some in the field of gifted education believe that Dabrowski’s notion of overexcitabilities, as they influence a person’s developmental potential, are indicators of that person’s giftedness.

Although not a theory aimed at explaining suicidal behavior, TPD has been used increasingly over the past 20 years to describe the lives of gifted students. For example, Cross, Cook, and Dixon (1996) considered aspects of this theory when conducting psychological autopsies of three gifted adolescents. The TPD includes numerous dynamisms (autonomous inner forces) at the five levels of development. As revealed in the Cross et al. study, several of these dynamisms associated with levels IV and V were operative in Reed’s life close to his successful suicide. Other dynamisms (dissatisfaction with oneself, disquietude with oneself, hierarchialization) associated with Level III were seen in Reed’s life as a younger person. The dynamisms seen in Reed’s life include self-awareness, autopsychotherapy, authentism, and personality ideal.

Somers (1981) claimed that strong relationships exist among college students’ cognitive complexity, emotional responsiveness, and value systems. These ideas are similar to Dabrowski’s. Reed’s internal conflict was in many ways representative of Dabrowski’s ideas about disintegration, manifesting both positive and negative characteristics. Negative disintegration is thought to reflect a self-centeredness that may have no moral or ethical component (Silverman, 1993). It is easy to see that a great potential for internal struggle exists when a person experiences both positive and negative aspects of disintegration and suffers from
bipolar disorder. Clearly, the inner conflict with which Reed dealt was multifaceted. Because we found evidence of positive and negative disintegration, as well as evidence of the tension necessary to impel him to a higher level of development, we worry that there was no emotional safety net to land him safely at the next level. Hence, he was left in a long period of emotional distress and suffered in the way that Shneidman (1996) described as “psychache.” While we are cautious about this interpretation, Dabrowski’s Theory of Positive Disintegration was helpful to use when considering the potential suicidality of a gifted person.

**Conclusions**

The psychological autopsy of Reed Ball’s life yielded three sets of findings: those that reflect only his life, those that compare his life with three previous psychological autopsies conducted, and those that reflect his parents’ observations and experiences of his life. The three sets of findings combined offer valuable information for identifying gifted students who may become suicidal. A few of the findings include the importance of understanding the interaction between the psychological makeup of a person in interaction with his or her environment. Parents, teachers, counselors, and peers should watch out for the same suicide correlates that have been identified for the general population of adolescents and young adults and should not consider aberrant behavior, belief systems, or both as a typical part of being a gifted person. Maintaining a relationship with a potentially suicidal gifted person is important as a protection against the tendency to restrict their interactions with others. Information about suicide needs to be immediately available to parents. Perhaps making this information widely available can save the lives of struggling gifted adolescents who are already experiencing greater life stressors than their nongifted peers (Coleman & Cross, 2001).

The psychological autopsy of Reed Ball’s life also demonstrates the importance of further study of suicide among gifted adolescents and young adults. This study provided an examination of Reed’s life from multiple perspectives and viewpoints. The authors came from a variety of backgrounds—research psychologist, licensed psychologist, and parent—all affected by suicide in a variety of ways. The diversity of these backgrounds proved advantageous in conducting this psychological autopsy in that it allowed a comprehensive view of Reed’s life, focusing not only on the pathology of suicide, but the strengths of the individual, as well. Future studies of suicide among gifted adolescents and young adults should include examination of risk factors of suicide among this population, along with examination of factors essential to resiliency and the prevention of suicide.

Finally, the psychological autopsy of Reed Ball is one of tragedy and inspiration. It shows the tragic loss family, friends, schools, peers, and others experience when an adolescent or young adult takes his or her life. However, this study also provides inspiration through the dedication of his family who, having experienced such a great and terrible loss, has since worked to prevent the loss of others. Reed Ball’s suicide demonstrates that the field of gifted and talented education needs to study and work to prevent the loss of others; the study and prevention of suicide needs to be a priority in the field. It also tells us that professionals, parents, and peers need to work together as a team in the prevention of suicide. Furthermore, professionals and parents need to provide safe environments that allow gifted and talented students to learn and grow and provide support for their mental health needs. And, most importantly, it tells us that communication and intervention are the key in preventing the loss of life to suicide. Even if there is some resistance in the individual at risk, it is essential that professionals, parents, and peers support each other in intervening and preventing such a death.

**References**


Appendix

Timeline of Significant Events in Reed’s Lifespan

<table>
<thead>
<tr>
<th>Year</th>
<th>Age</th>
<th>Grade</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973</td>
<td>Born</td>
<td>*</td>
<td>Parents: It’s important to note that Reed’s older brother was/is a very easy child, so it’s hard to judge which of Reed’s infant/toddler behaviors were unusual and which were just the difference between an easy child and a more “normal” one. We buy a house when Reed is 5 months old, and our life is very stable until the move to Canada in 1981. I am home full time. Our finances are stable. I start a babysitting coop that becomes a wonderful circle of friends for the parents and playmates for our children. We are busy in a church we all love. Other than Dave going through periods of very heavy overtime, it is definitely “Leave it to Beaver” time! Reed has more grumpy periods that I recall his brother having, but he’s definitely our “giggler”—a note in Reed’s baby book says he delights in his older brother blowing on his tummy and other typical baby games.</td>
</tr>
<tr>
<td>1974</td>
<td>1</td>
<td>*</td>
<td>My memory is that, from the get-go, Reed’s sleeping patterns are erratic; he’s a picky eater; he has grumpy periods that we can’t understand/resolve. He also seems to “enjoy ill health”—his stamina isn’t as good; minor colds/flu flatten him. Most kids start “jumping on the sofa” while still sick, but Reed will stay watching TV even after getting healthy. I’ve slotted the supporting anecdotes in the appropriate age period, but, in fact, they apply to his entire toddler/preschool time—in fact, his whole life.</td>
</tr>
<tr>
<td>1975</td>
<td>2</td>
<td>*</td>
<td>Reed learns the alphabet, but his version is ABCDFGI—and he is not interested in other alternatives!</td>
</tr>
<tr>
<td>1976</td>
<td>3</td>
<td>*</td>
<td>Eric joins Cub Scouts. I am a den mother—Reed delights in being the “mascot.” I am now taking care of two girls (age 5 and 7) before school, along with the other den mother’s son (age 6). They have so much fun. Reed is the youngest, but is definitely part of the group. Between this and the babysitting coop, the house is often filled with children. While Reed certainly joins in, he is the more likely to react more strongly to squabbles with playmates—they become “enemies.” We have to keep Reed out of the room while doing math flash cards with Eric, or Reed will beat out his older brother!</td>
</tr>
<tr>
<td>1977</td>
<td>4 Fall</td>
<td>Preschool 3 mornings/week. From notes in Reed’s baby book: Reed jumps off the diving board at the deep end and swims to me—not a care in the world! An age 4 baby book entry says Reed can get up at 6 a.m. to go potty and be back sound asleep when his brother wakes 15 minutes later. Another baby book entry: Reed can be clingy, weepy, get “stuck” on cry, but alternately is self-assured, plays by himself. He doesn’t require toys. He’s HAPPY! August, in a note talking about a day visit with another mom and her son who “was very tired and VERY cranky, so we had a good chance to talk about ‘crabby’ and how it had spoiled the day for all of us.”</td>
<td></td>
</tr>
<tr>
<td>1978</td>
<td>5 K Omaha, NE</td>
<td>* Christmas note about Reed beating us at Monopoly Kindergarten teacher is in her last year of teaching—okay, but nothing great. Reed goes willingly, but not excitedly. I remember him roaring into the house to go to the bathroom. He can’t be convinced to raise his hand and go while at school. Evidence of early manipulative capabilities shows up in a note from his Nana (Dave’s Mom) to the other Grandma: “Reed [is] a real young con man. I gave each $2 . . . Reed kept putting his in obvious places (like right under your feet!). Finally, Bonnie said, ‘Reed, why don’t you spend your money?’ Reed sidled up to me and, with that heavenly grin, said, ‘I was hoping that Nana would look at them and think they</td>
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were lonely and she’d put more with it.’ . . . [One day, while everyone else was out,] Reed asked if I would peel and slice an apple for him like I did for Gramps. About 20 minutes later, he came up with an empty dish saying, ‘Boy, is my father going to have your head when he gets home ’cause I’m not allowed to eat apples’ (Nana is terrified). When Dave comes home and asks Reed about it, he just grinned and said, ‘I really had Nana going, didn’t I?’"

1979 6 K/1
* Reed gets the excellent grade-1 teacher Eric had, so we are now confident that Reed is in good hands. He does well, but isn’t as enamored with this teacher as Eric was.

1980 7 1/2
* January 1980 note from Reed’s teacher: “Since Christmas vacation I have been concerned with Reed’s schoolwork. He seems highly distractible. He has difficulty completing his work, and it is usually poorly done. . . . We have discussed the problems and it seems difficult for Reed to take criticism.”
* February 1980: Doctor notes possible “minimal brain dysfunction.” The notes we made in preparation for that appointment say: “Reed exhibits periods of general crudness, highlighted by selfishness and blame shifting. He is run down, yet unable to catch up on sleep. We suspect that subsequent periods of high spirits and general cheerfulness coincide with breakthroughs in either mental or physical growth.”
* March-April: Psychological Assessment, including WISC-R and California Achievement test scores. Reed is rated as “Superior 98th & 99th percentile. Anecdotal comments include: “Reed is very exciting and sees immediately how to manipulate and reason.”
* Summer: Reed sets up a Kool-Aid stand on the hottest day of summer and does a brisk business
* Fall: Reed and his grade-2 (Omaha) teacher are kindred spirits. He blossoms under her class structure and nurturing. He loved the informal math competitions, the other kids, the interest centers set out for free time. He has a “girlfriend.”

1981 8 2/3
To Calgary 2/81: Notes: exacting moods (from parents)
* Reed’s grade-2 (Omaha) class has a huge going away party for him.

1982 9 3/4
Family changes employment (from parents)
* Dream Paper: not fitting in with peers (from Reed)

1983 10 4/5
Grade 4 notes: harassed by peers,
Family changes in employment continue (from parents and Reed)
* April: Dave starts new job; Bonny quits hers and is home for the summer. But, we all decide Mom (and therefore the family!) is happier when Mom is working, so she starts new job in October.
Notes: Fire, difficulty problem solving, thinks the world is against him, poor self-image, sorts peer group in very black-and-white manner of friends/enemies (from parents).
Essay: fascinated with fire — escape (from Reed) Notes: Fabrication, went to therapist, would not talk to therapist (from parents)
* Reed goes through period of phoning Bonny after she’s gone to work, complaining of stomach cramps. This
1987
1988
15

Reed LOVES Boys Choir and learns to play the recorder at school. Reed and a friend practice their
recorders on a packed commuter train as they go back and forth to choir.

1984
11
5/6
Psychoeducational Evaluation

* Spring 1994 review of this psychoeducational evaluation by Bonny’s therapist (M.A. in counseling psychology)
says the warning signs were there, but dismissed. WISC-R confirms previous IQ assessment.

* Grade 5 winter report card: “Reed has had greater success interacting with classroom peers this past term.

* February: Reed abruptly quits Boys Choir. Reed has been complaining that the director is totally fault finding, etc., but Reed loves the music and status—and the coming tour to Asia—so he sticks with it. But he
can’t tune out the harassment like the other boys. Finally, the director scolds him once too often when “it’s
not his fault” and Reed flees.

* From notes we made while trying to sort out Reed and Boys Choir: “Peer relations—teachers say Reed is
not a ‘groupy’ type, but he has selected friends and they are good relationships; on the other hand, we have
all noticed that Reed has poor stamina, vague ‘ill health.’”

* Fall: Grade 6 school incident: Someone taunts Reed when math tests are passed back and Reed didn’t get
100%. Reed flees home, won’t answer door/phone.

1985
12
6/7
Calgary Junior High School 1984 note: Reed and friend, thinks smarter than peers (from parents).

* The bullying ceases. About 6 weeks after school starts, I ask about the bullying. Reed says the teacher made
it plain that bullying was not allowed—bullies could either shape up or ship out. And they did. Reed calls
his junior and senior highs years his “healing time.”

* Reed tells me he “dekked” a long time “enemy.” I call the principal, who says Reed has just decided not to
be a victim anymore. He tells me not to worry. Reed is no bully.

1986
13
7/8
Suicidal ideation begins (from Reed’s later suicide note).

* The only incident I/we can think of is that he became fixated on a girl who rebuffed him at a Halloween
dance. Other than that, we haven’t a clue. He was doing well at school, though not brilliantly. He and
John are still good friends—and they’ve discovered computers!

* Grade 8 shows a high number of school absences. Also, teachers (from grade 5 onward) often note that
he daydreams, doesn’t complete homework, etc. Grades are a mixed bag depending on interest and
teacher. He/we just can’t get him to work on something that doesn’t interest him.

1987
14
8/9
Summer: Reed volunteers at a nursing home. We’re told he’s incredibly patient—the one person who was
able to get a 50ish (brain injured?) man to open up a bit by getting him to play Clues and Ladders.

* Reed is turning into quite the cook. Our Christmas letter says that, one evening, when asked to make
dessert for some guests, he made crépes filled with whipped cream and berries.

* Reed’s junior high chess team wins the city championship. Reed gets to play against Walter Brown, a
seven-time world champion.

* We try hosting an AFS student. It’s a disaster. The student leaves after 14 weeks, going through 4 more
homes during his year.

1988
15
9/10
The 1988 Winter Olympics are in Calgary. What a party! We attend several events, and all four of us
(including Reed) are ski-jump distance measurers. Reed is miffed because we insist he go to school on his off
days, and just won’t let go of it.

* Summer: Reed is finally old enough to work at the Calgary Stampede as a carny. He LOVES it. In fact
when he suicides in late June of 1994, one of my “consolations” is that he must have been in incredible
pain—otherwise, in true “Reed” fashion, he would have waited until after Stampede.

Fall: Reed starts high school in Calgary

* Fall: Eric goes to university; and immediately LOVES it. We miss him, but we treasure this special time
with Reed. When both boys are home, they are thick as thieves, so we have little one-on-one time with
either.

* Reed learns how to juggle—he’s always gravitated to “unique” hobbies—a need to “stand out” in the
crowd? Reed and I also start square dancing and continue for the next 3 years. We have a blast—he’s a
great dancer. Dave and Reed are partners in a hockey pool and spend much wonderful together time planning
trades and tracking the standings.
1989  16  10/11  Dream Paper: Daydreaming—escape peer relationships, reality not pleasant, analyze self/dreams—escape (from Reed). Grade 11 notes: missing work, withdrawing, described as depression/escapist cycle (from parents)

*  We work with school re the above, but, per previous attempts, Reed doesn’t respond to any techniques we have ever tried. All hope it’s just “typical” gifted kid who will take off once he gets to university with more challenge, etc.

*  Reed is 32nd in all of Canada in the Canadian Mathematics competition.

*  Summer: Reed gets a job at McDonald’s. He loves it. Within 18 months, he has worked up to “training coordinator.” He spends much time developing training plans on the computer, coaching new hires, etc. On the other hand, as soon as he has the seniority, he shifts himself to a Sat/Sun 5 a.m. to 2 p.m. shift, plus Tuesday after school to unload the truck. He says it beats all the 4-hour shifts, and he prefers working alone.

1990  17  11/12  Grade 12 notes: “Withdrawn now, wants to be last, did faint in class one month ago, looks tired” (from parents).

1991  18  12/University

*  Reed and his two best girl buddies (Judy and Joan) invite their six parents to a New Year’s Eve banquet, which they cook. The kitchen never recovers, but the food is excellent and we all have a wonderful time.

*  Reed finishes grade 12 early, doing his last course (Law) by correspondence and redoing his Physics with one-on-one help from a favorite teacher. Note that, despite the “poor grades,” missing homework, etc., his final average is 80%, which qualifies him for a provincial scholarship.

*  Reed quits McDonald’s. He and a new supervisor don’t get along, and he says he isn’t getting the perks he’s been promised for all his special projects.

*  He sets up his own company and, through cousin Fred, gets a contract with a major oil company to design a computer system to scan old blueprints, clean them up, and turn them into a working document to track corrosion. He pulls together the software bits brilliantly, but, when he runs into difficulty, he turns “escapist” and needs to be dragged through by parents.

*  April: Dave is laid off.

*  Reed escorts Judy, Joan, and another of his girl buddies to the grad dance. They have sooooo much fun!

*  September: Reed goes away to university; his brother is in the third year at the same university. They live in the same small dorm.

College Dorm Application/Questionnaire: not popular, likes to intrigue people, never totally challenged (from Reed) Letter: Poor social skills (from Reed)

1992  19  Winter: Work term

Summer: University

University Notes: Obsessively writing K, suicide file, knife (from parents and brother)

Fall: Work term

*  January–April: Work term in Toronto. Reed revels in the freedom! His voice bubbles when we talk on the phone. At work, the company is going through a major downsizing. Reed is left with no direction, so he hacks his way through the computer security system, e-mailing an extensive report to the head of security on his last day of work!

*  May–August: University: Someone apparently sees a suicide note on Reed’s computer and called security, who take away a kitchen knife (from Toronto work term), tells his brother (who had a major exam the next day), and closes the file. In the same time frame, Reed is writing (creezy) notes to a female dorm-mate. She gets scared and contacts the university. Reed formally acknowledges that the notes are his and promises not to bother her anymore. He must have been devastated.

*  September 1: Mother finishes job (she’d been notified in June of the layoff).

*  September–December: Reed has work term at Petro Canada, living at home (from parents) Reed’s writing: Judgment lacking, analyzing Susan v. Teresa, alludes to having relationship, inexperience (from Reed)

*  September 8: Dave starts new job in Vancouver.

Note: September: First known attempt by parents (from parents) Note: 40 caplets, ideation 6+ years, 12 or so attempts, 100% honest with self v. others, sanity leaving—may hurt someone, taking a lot of effort, letters to women (Teresa) (from Reed) October: Parents find note from suicide attempt (from parents) October: Writes J—he is losing control, loses trace of reality, memories of things not happening, needs to stay in control, knows what he is capable of if not in control, people not interesting (from Reed)
Mid-September: Reed is notified that he has flunked out of university. I don’t find the note until after the suicide attempt. I don’t think he is surprised. We try to comfort/listen, but Reed doesn’t (feel the need to?) talk. He’s doing well in his work term, and, in fact, has always done well in the “real” world, so perhaps this is better than continual academic probation.

October: Neither the crisis centre nor the employee assistance counselor we talk to pushes us to get Reed to counseling/medication. In fact, the counselor comments he “has his act together better than most kids” and that my job is to “take care of myself” and not to let Reed’s suicide attempt become the focus of my life. And Reed does have good street sense, marketable skills, good friends (including Judy and cousin Fred, Joan has moved to Vancouver), and he has wanted to be in charge of his own life since he was 2. So, the decision is to continue with the move. It might actually be better if we aren’t there to rescue/enable him. We buy a house in Vancouver that has a room for him, if he wants. We stay in touch by phone and e-mail, and send financial transfusions when necessary.

December: Reed moves into a rooming house in Calgary.

1993 20 Working (sort of) Writes journal to J (from Reed) Resume (from Reed)

* Reed gets a contract to set up computer software for our dentist. Reed enjoys that he works at night (when the office is closed). In April, he glories in moving into his own apartment.
* Reed visits us in May, while brother Eric and other friends and family are visiting. We have a great time. However, while there, he is notified that there has been a flood in the dentist office that has destroyed both computer and the backup he made. The insurance company will not hire him to redo the work.
* He “floats” all summer/fall. (He has money saved for expenses.) He has grandiose schemes of computer contracts, but little materializes. On the good side, he writes of finding real “kindred spirits” in early September. He, Judy, and these new friends become a close-knit “family.”
* Reed gets his own kitten “Solis.” The name is telling, for, as he carefully explains to our minister friend, “Solis” stands for “solitary,” “comfort giving,” and “sunshine.”

1994 21 Working (sort of)

* January: Dave has time off, so goes to visit Reed in Calgary. Dave says Reed seems fine.
* February (?): Reed begins to get contract computer work through cousin Fred, and then in another department at a major oil company.
* March 7: We hear from Fred that Reed has been brutally fired. Fred says that Reed isn’t answering the phone and he’s concerned. Apparently, the new supervisor had allowed Reed (at age 21!) to work at night, unsupervised. Reed had been caught exploring other floors and even switching computer equipment around. We ponder our options and finally write an e-mail with “hugs,” but also explaining the difference between a university and corporate environment. We later send a note from our cat offering purrs and snuggles in the hopes that Reed will phone us.
* March 17: We reconnect by phone. I have no recollection of the content, but my guess is that he quickly sidestepped talking about the firing.
* March 31: We phone our minister friend in Calgary who is also close to Reed and ask her to talk to Reed.
* April: Bonny realizes he is in a clinical depression and starts medication/counseling, focusing on understanding Reed. This therapist is the one who analyzes that Reed has had depressive cycles since the move to Calgary. She begins to coach us on how to support Reed and how to get Reed to try counseling/medication.
* May 16: Reed writes the suicide note that we find after his death.
* May 17: Reed writes chatty e-mail to us: “I’ve been busy, I have a new contract, so phone is busy or I’m sleeping.”
* May 31: Chatty e-mail from Reed to Dave comparing notes about a favorite TV show.
* June 20: Reed takes Judy out to dinner. They have a great time. Reed’s Visa bill shows eight restaurant charges in June, the first Visa changes in 4 months.
* June 27: Reed suicides.