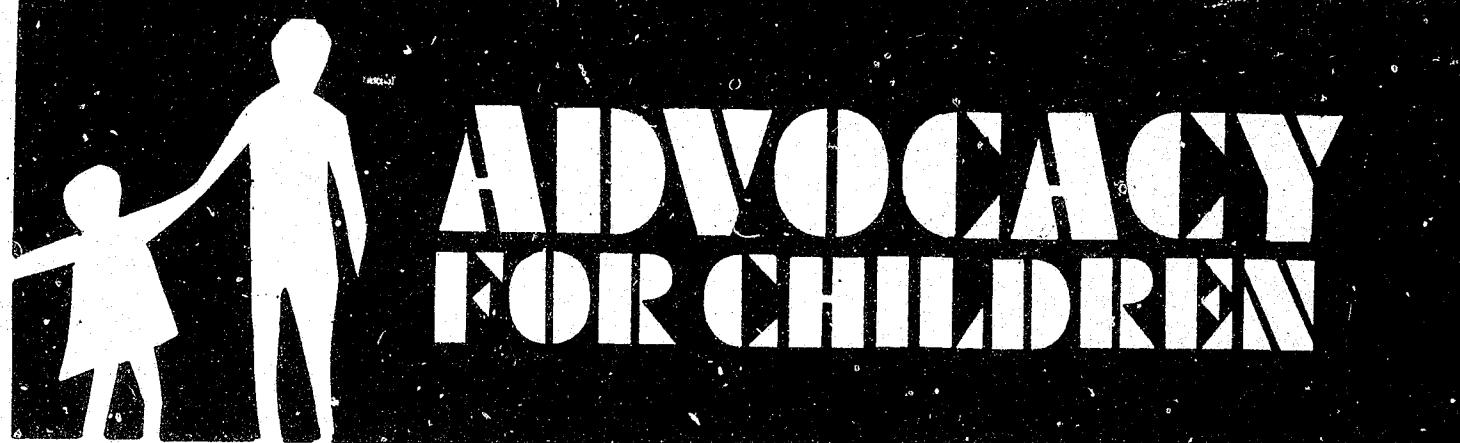


If you have issues viewing or accessing this file, please contact us at NCJRS.gov.



U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE / Office of Human Development Services
Administration for Children, Youth and Families / Children's Bureau / National Center for Child Advocacy

NCJRS

NOV 3 1978

FALL 1978

ACQUISITIONS

This issue of ADVOCACY FOR CHILDREN focuses on advocacy related to adolescent suicide. Included is an article by Dr. Calvin J. Frederick, Chief of Disaster Assistance and Emergency Mental Health, at the National Institute of Mental Health, 5600 Fishers Lane, Rockville, Maryland 20857.

The author was among several participants invited to a colloquium on adolescent suicide convened in April, 1978, by the Child Welfare Resource Information Exchange, a project of the National Center for Child Advocacy, U.S. Children's Bureau. The purpose of the colloquium was to provide guidance regarding: (1) the danger signals of impending suicidal behavior among young clients; and (2) the most useful methods of responding when such situations arise. Based on the proceedings of the colloquium there is currently being prepared a pamphlet for use by those who come into contact daily with adolescents, including social workers, teachers, and foster parents. The publication will be made available through the U.S. Children's Bureau in the fall of this year.

The ideas contained in this article are presented to stimulate your thinking on child advocacy. We hope that readers may be stimulated to corroborate, modify or differ with ideas presented.

1
2
3
4
5

51827

ADOLESCENT SUICIDE

by

Dr. Calvin J. Frederick*

A startling increase in suicide rates among younger age groups has continued to manifest itself for over two decades. The suicide rate in each of the age groups, 10-14 and 15-19, has tripled during this period. In the 15-19 year age group, the rate has doubled in the last ten years alone.

It is clear that a concerted effort must be made at the Federal, State, and local levels to find solutions to this tragic problem. The magnitude of the problem is too great for any one segment of the population alone to address it. Nevertheless, every interested group should appoint itself as a committee of one, so to speak, to attack this insidious disorder in the most effective manner possible. No single group should wait for another to take the lead in spearheading an effort to ameliorate this pervasive condition among our young people. Certainly, the Federal Government should consider taking a leading role in providing research grants, training materials, technical assistance, and consultation. These activities can be carried out at regional and local levels, with coordination of efforts.

There is now a reasonable body of knowledge available for dissemination and teaching purposes in a wide variety of settings, from high schools through professional and graduate schools. In addition, information can be obtained from the American Association of Suicidology and the National Institute of Mental Health and shared with interested groups.

*Dr. Frederick is Chief, Disaster Assistance and Emergency Mental Health, National Institute of Mental Health. He is an Associate Clinical Professor in the Department of Psychiatry and Behavioral Sciences, at the George Washington University School of Medicine, and Assistant Professor in the Department of Psychiatry and Behavioral Sciences, the Johns Hopkins University School of Medicine. The views expressed do not necessarily represent the policies or position of the National Institute of Mental Health or the U.S. Department of Health, Education, and Welfare.

Advocacy efforts to heighten awareness of adolescent suicide and of effective ways to intervene to prevent it should be undertaken in the following spheres:

1. Secondary schools

Students: The peers of suicidal adolescents are often the most likely source of initial contact and possible rescue. Courses should be taught in health classes at the high school level, incorporating information about suicidal behavior. Clues to self-destructive acts and psychological first-aid procedures can be readily taught and assimilated at the high school level. Discussion groups, films, and printed matter provide avenues of inestimable value in the dissemination of knowledge about suicide prevention.

Teachers and counselors: A sensitive and dedicated teacher or counselor can bridge the generation gap and save a life when suicidal clues are missed or ignored by other persons. Participating in school health programs in suicide prevention, attending workshops on the topic, and conducting case conferences will supply these secondary personnel with much needed information about intervention procedures with suicidal youth.

2. Parents

Parent and Teacher Association groups and other parent organizations offer a ready-made arena for the dissemination and utilization of knowledge about youthful conflicts which all too frequently point in the direction of self-destructive behavior. Despite the general gap, on occasion, a youngster is able to relate more effectively to another parent, or parental surrogate, than to his or her own family. A breakdown in communication between parents and offspring is part of the problem which precipitates suicidal behavior. Befriending a youngster is vital during a period of emotional stress and crisis.

3. Clergy

For church-affiliated youngsters, the clergy can and should exert a positive influence. This should be done without fostering guilt, but with an open and accepting approach. Many clergymen can be useful sources of help in time of need if they are aware of the problems encountered by young people and incorporate information about suicide prevention in their pastoral work. Care must be taken not to create anxiety in the youngster by evoking feelings of shame, which would compound an already bitter state of affairs.

4. Professionals

Non-mental health professionals: All non-mental health professionals should contact their local health organizations for information about suicide prevention. Inquiries should be made into the availability of workshops, institutes, or printed matter on the subject. Some studies have indicated that many suicidal persons have taken their lives within 30 to 60 days after consulting a physician. If the physician had been alert to some of the conflicts pointing to suicide, the person's life could have been saved. With the advent of an increase in drug abuse, alcoholism, and venereal disease, physicians can play a more important gatekeeper role in spotting potential problems and making appropriate referrals.

Mental health professionals: Curiously, even many mental health professionals are not as skillfully trained in suicide prevention activities as they should be. It is the rare department of psychiatry, psychology, or other department with mental health curricula which teaches a prescribed course in suicide prevention activities. The knowledge of both suicide prevention techniques and psychopharmacology should be standard parts of any up-to-date curriculum. Moreover, every hospital emergency room, clinic, and mental health center should bring their personnel up-to-date in this newly developed and expanding field of knowledge. An established referral system and continuity of service should follow every suicidal intake. Workable phone numbers should be readily available to every relevant group in the community so that needed services can be obtained.

The Continuum of Suicidal Behavior

Self-destructive acts can best be understood by placing them on a continuum, so that a range of behaviors can be addressed. Suicidal behavior is rarely carried out impulsively. In other words, the uncontrollable impulse notion of suicide is not a viable concept. In cases which appear to be impulsive, inevitably, the individual has been under strain and has given some thought to suicide prior to the act. The author uses three terms to describe the continuum of suicidal behavior.

Self-assaultive behavior indicates assaultive acts upon the self. This behavior is not often clearly suicidal. So-called "accident prone" persons may fall in this category. Even small youngsters will repeatedly ingest the same poisonous material, which requires being lavaged in order to save their lives. Sometimes, they do not survive, particularly with repetitions of the same behavior. Young children may verbalize the fact that they are going to run

away or hurt themselves in order to obtain needed affection and love. These signs should not be ignored, since they may be precursors to suicidal behavior, which is more fully manifested in later years. When a child makes such a threat, it is always a pathetic cry for help, so to speak, and indicates a noteworthy lack of parent-child relationships.

Self-destructive behavior usually indicates a more serious problem than that found in the self-assaultive range. All along the continuum, behavior will occur in varying degrees of intensity, as a function of awareness and intent. "Psychological equivalents" of suicide are sometimes ignored or missed because they lie beneath the level of open awareness. Illustrative examples are youngsters with diabetes who fail to take medication or eat properly, or those with serious cardiac difficulties who neglect their health after having been warned about the consequences. Another example is a teenager who continues to drive recklessly, knowing chances are high that he may kill himself. The degree of understanding and the deliberateness of the act indicate how closely the self-destructive behavior approaches unmistakable suicide.

Suicidal acts. Clear-cut suicidal behavior is that about which there is little reasonable doubt when compared with the other two major points in the continuum. Suicide is defined as any willful act designed to bring about an end to one's own life. There is a definite and final quality to suicidal behavior which distinguishes it, in principle, from the other two major points on the continuum, even though this difference may be a matter of degree. When a person leaves a suicide note, and engages in a lethal act, the suicide is relatively unequivocal. Nevertheless, a state of ambivalence always exists, that is, the person wishes to live and die at the same time. Sometimes an individual will be found dead with a telephone in hand, attempting to reach help even at the last moment, or the hope exists that the suicidal note will be discovered in time to effect a rescue.

Adolescent Profiles of Suicide

A typical profile for a young suicidal male is that in which there has been an inadequate or broken father-son relationship. The son has been separated from the father through death, a divorce, or some other means, before the youngster reaches the age of 16. The father has usually been busily engaged in his own activities, and has often been successful at other pursuits to the neglect of his son. The boy may have spent some time away from the home setting, which adds to the feeling of rejection. The young male has self-assessed traits of worry, anxiety, rejection, sleeplessness, and heavy smoking, which indicate the tension being experienced. Recently, many youngsters have also

engaged in some form of drug abuse and alcoholism, along with the behavior just noted. This is not a necessary requirement, however, for suicidal behavior; essentially, it adds to an existing problem.

Young females, by contrast, show a profile which indicates the presence of a narcissistic and demanding mother, with a weak and ineffectual father figure. The demands of the mother become too much for the daughter to bear, and she is unable to receive support and assistance from the father. At this point, she turns instead to a boyfriend, hoping that he will meet her psychological needs and resolve her conflicts. The young man, of course, is unable to manage the problem, with the result that the girl feels further rejection. At this point, she makes a suicidal attempt.

Although young females have a higher suicide attempt rate, males have a higher rate of committed suicides because they use more lethal means. Most young people continue to speak about the pressure they feel surrounding the times in which they live. The pressure is a function of socioeconomic conditions, of the home, peers, and self-induced pressure, based upon need for feelings of personal worth and achievement. This combination, along with a breakdown in the nuclear family unit, seems to be responsible for the heightened increase in suicide over the last 20 years.

Clues to Suicide

Feelings of loss of confidence, humiliation, traumatic events, recent loss of a job, school failure, death of a loved one, etc., are common precipitating events which may lead to suicide. Clues are verbal, behavioral, and situational. Each of these may express themselves directly or indirectly. Direct clues are those which are clear and overt. Indirect clues are those which are more hidden or covert. An example of an overt clue would be the purchase of a lethal object or instrument. Examples of more covert clues would be disturbances in sleep, loss of appetite, changes in mood, and the giving away of a prized possession, with the comment that the person in question would not be needing it any longer. When present, signs of depression would be important to consider in adolescents as well as in adults. However, depression does not always manifest itself in suicide, especially among adolescents. It is a mistake to believe that an individual must be clinically depressed in order to commit suicide. General efficiency, however, is apt to decline, whether on the job or in school.

Three signs which almost invariably appear are what the author calls the three "H's;" namely, haplessness, helplessness, and hopelessness. By haplessness we mean a quality of self-perceived ineptitude. The individual has experienced a number of bad breaks, things have simply not gone right; for example, a series of accidents may have occurred.

Following this, the individual becomes helpless to deal with the conflicts and problems with which he or she is presented. The potential victim simply does not possess the wherewithal to pull himself together. At this point, the loss of hope is apt to set in, and when that development occurs, the possibility of suicide increases markedly.

Signs of suicide may include a history of child abuse or neglect. There is mounting clinical evidence to indicate that future violence, including suicide, can develop from childhood. If youngsters feel openly rejected and humiliated by their parents, this feeling should be noted, even if severe physical punishment is absent. It is useful to look for verbal or behavioral signs which suggest a desire to get even with parents. A prominent component in suicidal behavior is the wish to make those left behind sorry for the maltreatment they felt when alive.

Covert verbal clues may take these forms: (1) talking about another individual's suicidal thoughts; (2) inquiring about death and the hereafter, usually referring to a third person; and (3) discussing legal matters like the disposal of personal property, or the handling of documents such as insurance policies or wills.

Psychological First-Aid

The following are preventive steps for dealing with the suicidal youngster:

1. Listen.

The first thing a person in a mental crisis needs is someone who will really hear what is being said. Every effort should be made to understand the mood and meaning beneath the words.

2. Evaluate the seriousness of the youngster's thoughts.

Plans which are openly self-destructive are likely to be more acute than when the plans and thinking are less definite. Evaluate the lethality.

3. Evaluate the intensity or severity of the emotional disturbance.

Sometimes youngsters are extremely upset, but not suicidal. The emotional distress must be taken in context with the lethality involved. When the depressed person becomes agitated and begins to move about restlessly, it is usually cause for alarm.

4. Take every complaint and feeling the patient expresses seriously.

Do not dismiss or undervalue what the person is saying. In some instances, the victim may express disturbance in a low key; yet, beneath the apparent calm there are deeply distressed feelings. All suicidal talk or ideation should be taken seriously. Suicidal persons appear to be their own worst enemies by engaging in seemingly foolhardy acts which are contrary to their own best interests.

5. Do not avoid asking directly if the individual has thought of suicide.

Experience shows that harm is rarely done by inquiring directly into such thoughts at an appropriate time. In fact, the individual frequently welcomes the question and is glad to have the opportunity to bring it out openly.

6. Do not be misled by the youngster's comments that the emotional crisis is over.

While the youth may feel initial relief after talking of suicide, the same thinking will often recur later. Follow-up is vital to insure productive treatment.

7. Be affirmative but supportive.

Strong, stable guideposts are essential in the life of a distressed individual. Provide emotional strength by giving the impression that you know what you are doing, and that everything possible will be done to prevent the ending of the victim's life.

8. Evaluate the resources available.

The individual can possess inner psychological resources, including various mechanisms for rationalization and intellectualization which can be strengthened and supported, and outer resources in the environment such as ministers, relatives, and friends whom one can contact. If these are absent, the problem is much more serious. Continuing observation and support are crucial.

9. Act specifically.

Do something tangible; that is, give the youngster something definite to hang onto such as arranging for a later interview or contact with another person. Nothing is more frustrating than to feel that one hasn't received anything from the meeting.

10. Feel free to ask for assistance and consultation.

Call upon whomever is needed, depending upon the severity of the case. Do not try to handle everything alone. Convey an attitude of firmness and composure so that the victim will feel something realistic and appropriate is being done to help.

Additional preventive techniques for dealing with persons in a suicide crisis may require the following: (1) arrange for a receptive individual to stay with the youth during the acute crisis; (2) make the environment as safe and provocation-free as possible; (3) never challenge the individual in an attempt to shock him or her out of his beliefs; (4) do not try to win arguments about suicide, as they cannot be won; (5) always offer and supply emotional support for life as opposed to death; (6) give reassurance that depressed feelings are temporary and will pass; (7) underscore the fact that if the choice is to die, the decision can never be reversible; (8) emphasize that while life exists, there is always a chance for help and resolution of the problems, but that death is final; (9) focus upon survivors by reminding the youngster about the right of others, that a stigma will be left on siblings, family members, and friends, and that he will predispose his friends and family to emotional problems or suicide; (10) call in family and friends to help establish a lifeline; (11) allow the youngster to ventilate his feelings; and (12) do not leave the person isolated or unobserved for any appreciable time, especially during acute distress, even at night.

These procedures can help restore feelings of personal worth and dignity, which are equally as important to the young person as to the adult. In so doing, the intervening person can make the difference between life and death, and a potentially productive young citizen may survive a needless loss of life.

For information about suicide prevention, write to:

Ms. Sandra Lopez
Administrative Secretary
American Association of Suicidology
P.O. Box 3264
Houston, Texas 77001.

BIBLIOGRAPHY

1. Frederick, C. J. and Lague, L. Dealing with the crisis of suicide. Public Affairs Committee. New York: 1972.
2. Frederick, C. J. Trends in mental health: Self-destructive behavior among younger age groups. DHEW Publication No. (ADM) 76-365, 1976.
3. Frederick, C. J. Suicide in the United States. Health Education, 8(6):17-22, 1977.
4. Frederick, C. J. Crisis intervention and emergency mental health. In: Health in Action, ed. W. R. Johnson, Holt, Rinehart & Winston, New York, 1977.
5. Frederick, C. J. Current trends in suicidal behavior in the United States. American Journal of Psychotherapy, 32:172-200, 1978.

CALENDAR OF EVENTS

August 29-31

Danvers, Massachusetts, Third National Planning Conference. Contact: Ann Sindelar, Regional Research Institute for Human Services, Portland State University, P.O. Box 751, Portland, Oregon 97207, (503) 229-4055.

August 29 - September 1

Orlando, Florida, Southeast Regional Conference, American Public Welfare Association. Contact: Rex Newman, (904) 488-9126.

September 26

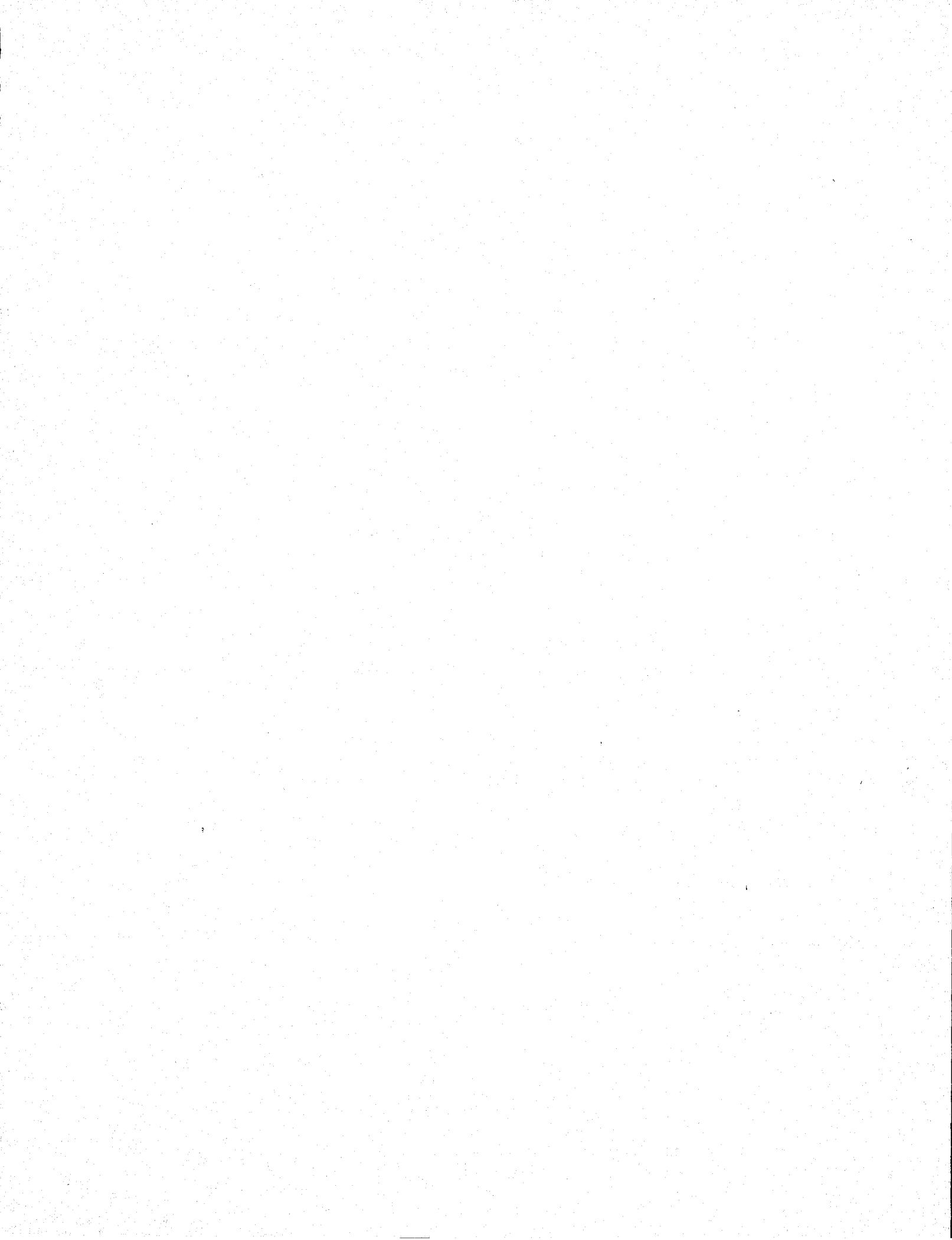
Edison, New Jersey, Advocacy for Children Out of Their Homes. Contact: Association for Children of New Jersey, 251 Park Street, Montclair, New Jersey 07043.

October 22-25

St. Paul, Minnesota, National Institute on Early Education. Contact: Mary Ambroe, Coordinator, St. Paul Public Schools, Department of Special Education, 360 Calborne Street, St. Paul, Minnesota 55102.

October 31 - November 2

Nashville, Tennessee, A National Symposium on "Fulfilling the Promise of Permanence." Contact: Director, CIP Project, National Council of Juvenile and Family Court Judges, P.O. Box 8000, Reno, Nevada 89507.



END