University of Northern Iowa

UNI ScholarWorks

1981

Family crisis intervention with an adolescent at risk of suicide: A study of the family crisis intervention unit of Polk County, Iowa

Michael Perry Bleadorn
University of Northern Iowa

Let us know how access to this document benefits you

Recommended Citation

Family crisis intervention with an adolescent at risk of suicide: A study of the family crisis intervention unit of Polk County, Iowa

Abstract

Suicide: the act of killing one's self intentionally. The word reaches out and grabs every one of us who reads or hears it. It is a word which is at the very heart of our innermost fears. Suicide is an action which has been romantically praised in western culture by William Shakespeare in "Romeo and Juliet." It has been glorified in the eastern culture through the ritual of Hari-kiri and also in the kamakazi mission of death. "Suicide, which once ranked twenty-second on the list of causes of death in the United States, now rates tenth, and in some states sixth" (Grollman, 1971, p. 8). Grollman (1971), contends that to most people, self-imposed death was some bizarre form of unconventional behavior, usually signifying insanity. Today, with a greater awareness of the increasing complexity of human life, we must acknowledge that suicide is more than just a personal decision; it is a disease of civilization (p. 5). Suicide is the action which man uses to destroy everything that he has attempted to preserve. Suicide in youth is a t

FAMILY CRISIS INTERVENTION WITH AN ADOLESCENT AT RISK OF

SUICIDE: A STUDY OF THE FAMILY CRISIS INTERVENTION UNIT

OF POLK COUNTY, IOWA

———————

A Research Paper

Presented to

the Department of School Administration

and Personnel Services

University of Northern Iowa

———————

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

———————

by

Michael Perry Bleadorn

December 1981

This Research Paper by: Michael Perry Bleadorn

Entitled: FAMILY CRISIS INTERVENTION WITH AN ADOLESCENT AT RISK OF

SUICIDE: A STUDY OF THE FAMILY CRISIS INTERVENTION

UNIT OF POLK COUNTY, IOWA

has been approved as meeting the research paper requirement for the

Degree of Master of Arts.

November 23, 1981

Date Approved

Audrey L. Smith

Director of Research Paper

November 24, 1981

Date Received

Robert T. Lembke

Graduate Faculty Adviser

Dec 5, 1981

Date Received

Robert J. Krajewski

Head, Department of School
Administration and Personnel
Services

TABLE OF CONTENTS

Chapter 1

INTRODUCTION

Suicide: the act of killing one's self intentionally. The
word reaches out and grabs every one of us who reads or hears it.
It is a word which is at the very heart of our innermost fears.
Suicide is an action which has been romantically praised in
western culture by William Shakespeare in "Romeo and Juliet." It
has been glorified in the eastern culture through the ritual of
Hari-kiri and also in the kamakazi mission of death. "Suicide,
which once ranked twenty-second on the list of causes of death in
the United States, now rates tenth, and in some states sixth"
(Grollman, 1971, p. 8). Grollman (1971), contends that to most
people,

> self-imposed death was some bizarre form of
> unconventional behavior, usually signifying insanity.
> Today, with a greater awareness of the increasing
> complexity of human life, we must acknowledge that
> suicide is more than just a personal decision; it
> is a disease of civilization (p. 5).

Suicide is the action which man uses to destroy everything that he
has attempted to preserve.

Suicide in youth is a tragic event for us to deal with in
western culture. The self-inflicted death of a young person con-
fronts us with the reality of the stress we put upon adolescents
in our society, the expectations we expect them to fulfill, and
our own failure to meet their needs. According to Miller (1975),

1

An investigation of suicide is difficult due to
the unreliability of the statistical data. Most of
the data depends on the reports of local coroners,
and authorities agree that a large number of
suicides go unreported because of social, religious,
and legal taboos (p. 11).

Miller (1975) goes on to say that "given these statistical problems

it is estimated that in the United States suicide is the third

leading cause of death in the 15-19 year old age group" (p. 11).

Late adolescents who are in college pose an even higher suicide

risk.

Youth suicide is a problem that involves the family as well

as the youth at risk. Wenz (1979) lists six factors to which

suicidal acts are related:

1. Parent-child difficulties resulting in the loss
of love and approval from the parents.

2. Stresses of competition and achievement in the
school setting, and actual or anticipated school failure.

3. Depression and problems dealing with sexual
identification.

4. Parental loss.

5. Rejection, withdrawal, and progressive social
isolation.

6. The crisis of adolescence (p. 19-20).

All of these factors either directly or indirectly involve the

family, and must be dealt with as a family issue. Speck, in

Resnik (1968), states:

The family therapy approach uses, as the unit to
be treated, the naturally occuring group who live and
interact in the same dwelling, plus various signifi-
cant others in the social context of the family.
Suicide is regarded as a symptom of family system
malfunction, expressed via one member of the system
(p. 341).

> When a child has died, the survivors - both parents
> and the remaining child or children - must adapt to a
> new reality. A complex family process begins, far more
> complicated than the sum of the individual responses
> of the survivors (Krell and Rabkin, 1979, p. 479).

When the family becomes aware that a young person is at risk of
suicide the same process is involved as that which occurs when a
child dies. The young person provides a crisis situation for the
family. The family, being pushed by the threat of suicide that the
youth is presenting, looks for help in dealing with the problem.
The traditional forms of help the family have sought out have been
medical help for the youth, or psychological help for the youth
and/or the family. Families seeking counseling have had to wait
until day-time hours to schedule office hour appointments to come
in to see a counselor, often having to wait a week or more before
they could get in. This model often limits the family to a small
one hour per week session. In the late sixties, as the rate of
youth suicide increased, it became apparent to mental health
professionals that this one hour per week office hour counseling
was not meeting the needs of families.

The need shown was that there needed to be some type of
immediate crisis intervention to assist the family at the time of
crisis. Many of the early forms of crisis services were provided
by phone counseling agencies. Phone counseling opened the way for
walk-in counseling crisis centers which were often affiliated with
hospitals or private clinics. Each of these services provided a
needed service but left much to be desired. In recent years a
new form of crisis intervention has been developed, the thrust
which has been to meet the individual or family at the time of

crisis in their home or wherever they might choose to meet. The counselor is coming to the clients rather than the clients coming to the counselor.

The youth at risk of suicide causes the family to be in a state of disequilibrium, a crisis. This state is discomforting to the family and energizes them to use their resources to seek help for the individual and the family. Crisis intervention with the family in their home at the time of crisis provides the family with an opportunity to deal with the problem when they are motivated to change, and in the case of a youth threatening suicide, a chance to prevent a tragedy.

Statement of the Problem

Youth suicide is an ever-increasing problem which reaches across all social and economic classes. For families in Polk County, Iowa there has been no formalized system of immediate crisis interventions to deal with the youth and the family in their environment at the time of crisis. The lack of such a program was assessed to be a need in Polk County. A program was developed in 1979 and 1980 and implemented in the fall of 1980 to provide a mobile crisis intervention unit to work with families with the above problem and other crisis situations the families might identify.

Purpose of the Study

The purpose of this study is to review the first year of operation (October 1, 1980 to September 30, 1981) of the Family Crisis Intervention Unit of Polk County, Iowa in working with families with an adolescent at risk of suicide.

Procedure

This paper will review present and past literature on adolescent suicide. Also to be reviewed is the literature pertaining to crisis intervention for suicidal-prone adolescents.

The program design of the Family Crisis Intervention Unit of Polk County, Iowa will be presented. The data on families seen with an adolescent at risk of suicide will be delineated. In delineating the data three areas will be reviewed: 1) length of crisis contact, 2) service provided following the initial contact, and 3) the number and percentage of families who chose to continue counseling or who felt that the crisis was resolved.

Definition of Terms

For the purpose of this paper "crisis intervention" will refer to face-to-face intervention. Phone counseling or any other such form of crisis work will be referred to by name.

"FCIU" will refer to the Family Crisis Intervention Unit of Polk County, Iowa.

The terms "counselor" and "therapist" will be used interchangeably.

The definition of an "adolescent at risk of suicide" will be - any youth between the ages of 12 and 19 years who has attempted suicide or who has threatened suicide.

Chapter 2

REVIEW OF RELATED LITERATURE

This study is a review of the first year of operation of
the Family Crisis Intervention Unit of Polk County, Iowa, (FCIU) in
treating families with an adolescent at risk of suicide.

This chapter will review related literature pertaining to
myths about suicide, suicide motives and states, personality
characteristics of suicide attempters, and theories of suicide. An
additional section will review the literature pertaining to the
history and development of family crisis intervention and treatment.

MYTHS ABOUT SUICIDE

Pokorny, (cited by Resnik, 1968), gives an extensive look
at the mythology which surrounds suicide. Two of the categories
cited by Pokorny are General myths and myths regarding Cause of
suicide. There are two such myths within the "General" category:

"1) People who talk about suicide won't commit suicide"
(Resnik, 1968, p. 57). Studies have indicated that 60 to 80% of
the people who commit suicide have communicated their intent
before the action. These messages may be obvious or hidden.
Examples of the obvious messages are fairly direct whereas the
hidden messages are often harder to detect. Because a message is
hidden it is not any less dangerous than an obvious message.

"2) Suicide happens without warning" (Resnik, 1968, p.
58). As addressed in the previous myth, suicidal intention is

often expressed. Other than direct or indirect spoken messages, which may indicate suicidal intent, there are behavioral messages that the individual may communicate.

"3) Suicide and attempted suicide are the same type of behavior" (Resnik, 1968, p. 58). Attempted suicide should not be viewed as failure as the attempter may have achieved his/her goal by the attempt. The tragedy of the use of attempting suicide as a means to reach certain goals is that the individual may go too far and kill him/her self.

There are three subcategories within myths about "Causes" of suicide: Sociological, psychological and biological. The "Causes" will be treated under these headings.

Sociological myths:

"1) Suicide occurs only in specific classes of people" (Resnik, 1968, p. 60). Suicide has often been thought of as an alternative to the poor and to the rich. The reason for this thought has been that the struggle the poor are under to survive, such as helplessness, contributes to suicide, and that for the rich, a sense of boredom and pointlessness of life contributes. These reasons may be valid, yet they also apply to all social classes. The important factor, according to Resnik, seems to be the individual's ability to integrate oneself into one's own culture.

"2) Good circumstances prevent suicide" (Resnik, 1968, p. 60). Pokorny, in Resnik, states that frequently the opposite is true. Studies of the military show that officers commit suicide at a higher rate than do enlisted men. Suicide in professional persons *is also quite high, as is the rate of suicide in youth from privileged families.*

"3) Suicide can be explained fully by sociological factors" (Resnik, 1968, p. 60). Many theorists believe that the best understanding of suicide is obtained when both psychological and sociological factors are considered.

Psychological myths:

"1) Motives or causes are easily established" (Resnik, 1968, p. 62). This myth is generated by our society's tendency to attach quickly to a reason or motive which will satisfy us. As the suicide is looked into on a deeper level often the apparent cause was preceeded by another cause.

"2) Suicide occurs in a single disease, depression" (Resnik, 1968, p. 63). The idea that only the depressed commit suicide is a fallacy, says Pokorny (Resnik, 1968).

"3) All suicides are on the basis of the same motive" (Resnik, 1968, p. 63). The path to suicide or suicidal behavior can take many routes. These pathways that the individual follows may not be directed or motivated by the same motive that another individual may have had. Given the individual's own psyche, the motives for suicide are unique to the individual within their perception of the situation.

"4) Suicide is a crazy or insane act" (Resnik, 1968, p. 64). Suicide is often a well-thought-out, rational act. The person may have been unable to come up with a solution to the problem other than to take their own life. Pokorny cites Schneidman's research and points out "that schizophrenics do not ordinarily commit suicide in acute illness - as in response to severe hallucinations, delusions or panic - but rather during the improved state, while on pass, or soon after discharge from the hospital" (Resnik, 1968, p. 64).

Biological myths:

"1) Suicide is inherited" (Resnik, 1968, p. 65). Suicide that runs through families is not transmitted genetically. This type of history in a family indicates that this myth is being passed on psychologically. Suicide that runs in families involves the whole psychological make-up of the family. Family members validate to one another that suicide is a problem-solving method that the family will accept under the guise of biological causation.

In summary, the myths about suicide fall into two categories, "General" and "Cause". Within the "Cause" mythology are three sub-categories, sociological, psychological and biological. Each of these myths are excepted in similar enthusiasm by society. It has become the task of mental health professionals to dispell these myths.

SUICIDAL MOTIVES

Toolan (Resnik, 1968) groups the motives of suicide among adolescents into five categories as follows.

"1) Anger at another which is internalized in the form of guilt or depression" (Resnik, 1968, p. 222). In youth this anger is generally directed at one of the parents. The youth who is distressed over the amount of anger toward the parent or the result of a fight with a parent can become very depressed. Often this depression is a result of some guilt the youth may be feeling. This guilt may be brought on by the youth's own feelings, or it may have been projected upon the youth by an adult who uses guilt as a tool to regain control. Regardless of the source of the guilt or depression the result can be the same.

"2) Attempts to manipulate another, to gain love and affection, or to punish another" (Resnik, 1968, p. 222). Attempted suicide by youth is often a method used to gain love from a parent or from a peer. The youth is testing the extent of love toward themselves that the people around them have. Adolescent girls and boys often threaten suicide or attempt suicide when threatened with rejection from a boyfriend or girlfriend. Fantasy thoughts of punishing significant others through one's death are also prevalent in youth. These fantasies are often directed at parents who the youth feels have treated them unfairly.

"3) A signal of distress" (Resnik, 1968, p. 222). Youth often feel that adults do not hear them or listen to them. The threat of suicide or an unsuccessful attempt at suicide can get a message across that says "I need help." The idea of asking for help may be more threatening than the possibility of taking one's life.

"4) Reactions to feelings of inner disintegration" (Resnik, 1968, p. 223). This type of suicidal motive results from a desire for peace and tranquility. The youth may wish to try out some fantasies about death and experiment with their own life. As cited by Toolan these are likely to be serious attempts.

"5) A desire to join a dead relative" (Resnik, 1968, p. 223). The loss of a significant person in an adolescent's life can trigger a suicide attempt. Anniversary suicides are not uncommon among youth, that is, the youth takes their life on a common date to that of the significant other.

Jerome Motto (1978) has developed an etiology of suicidal states. He states that "an array of biological, social, and psychological elements interact to produce the impulse to end one's life. These elements can be grouped into four basic etiological patterns which are not mutually exclusive" (Motto, 1978, p. 537).

Listed first by Motto (1978) is "depressive suicide" (Motto, 1978, p. 537). He describes this as a sequence involving an intense, homicidal level of rage that the person represses but experiences as impulses to kill oneself. Motto feels that 45-50% of suicides fall into this category. This rage is generated on those to whom the person is emotionally dependent. Motto believes that an important element in the depressed suicidal state is the sense of isolation that the person may have. This depression and rage may be repressed so that when the person attempts suicide it is a shock to the family. This may be a double blow to the attempter who survives if he/she learns that the messages they felt they were sending were not received.

'Suicide for the relief of pain" (Motto, 1978, p. 538) is the suicidal signal that the individual has reached or exceeded their ability to tolerate emotional or physical pain. Motto believes that this interplay reflects the intensity of pain to which a person is subjected and the level of the person's pain threshold. When that pain threshold is exceeded the person has three choices: "distortion of reality to reduce the pain; use of drugs/alcohol to raise the pain threshold; or suicide" (Motto, 1978, p. 538). These are the choices the person has if they choose not to use the available psychological defenses they have. "Persons with a low-pain threshold constitute a chronic risk for suicidal behavior because so many common life

experiences can cause the threshold to be exceeded" (Motto, 1978,

p. 530). This type of suicide accounts for 35-40% of all suicides.

"Symbolic suicide" (Motto, 1978, p. 530) accounts for 5-10%

of suicides, according to Motto. The idea that one's death will

accomplish a goal is the root of this cause. Included in this group

are religious suicides and altruistic suicides.

The fourth group cited by Motto is "suicide resulting from

organic dysfunction" (Motto, 1978, p. 539). This is a poorly defined

group because the suicidal mechanism is unclear and often unreported.

The recognition of the suicidal state is very important for

any therapist. As mentioned earlier, according to Toolan and Motto,

the suicidal state often revolves around depression, although not

exclusively. Common indicators of depression are "sleeplessness,

crying spells, loss of appetite, self criticism, listlessness, apathy,

feelings of guilt, hopelessness" (Motto, 1978, p. 539). As these

feelings grow they expand into

> excessive tension, weight loss, exaggerated fears
> of cancer or other phsycial impairments, loss of
> previous interest, social withdrawal, indecisiveness,
> a sense of helplessness, feelings of being a failure
> and of being a burden to others, preoccupation with
> unpleasant thoughts (such as death and dying), ideas
> of self-punishment, and self-destructive thoughts,
> fantasies, or dreams (Motto, 1978, p. 539).

The recognition of termination behavior in suicidal adolescents is

of utmost importance. Termination behavior refers to the action the

youths take as they arrange their affairs before they die. This

behavior can be seen as the youth may be giving away valuable objects

or sentimental treasures. Statements the youth may make about getting

everything straightened out with friends and parents before it's too

late are a possible indication of termination behavior.

A review of suicidal motives and states indicate that there are several potential motives for suicide. Several motives may arise if the person is in a state of depression. As indicated in the research, 45-50% of suicides occur when the individual is in a depressed state. The recognition of depression and suicidal intent is often keyed by observing the individual acting out some termination behavior. Termination behavior indicates actions the individual may be taking in putting their life in order before they commit suicide. Suicidal motives and states may possibly be observed in those individuals who have personality characteristics similar to suicide attempters.

PERSONALITY CHARACTERISTICS OF SUICIDE ATTEMPTERS

Patsiokas (1979) constructed a study by which she could test 49 patients at the Veterans Administration Hospital, Salem, Virginia who had attempted suicide. She hypothesized that suicide attempters would be more cognitively rigid, field dependent, and more cognitively impulsive than the control group. The subjects, all male, were given a battery of tests which would be compared to a like battery given to the control group. The suicide attempters were found to be more cognitively rigid by their lower mean scores on the Alternate Uses Test. Patsiokas (1979) states,

> they can be viewed as not possessing the ability to display diversity in coping with their stressors. The cognitively rigid person has difficulty conceiving and following through on suggestions of new behavior options and may be deterred from contemplating anything other than his stressful life situation. A suicide attempt for such individuals may become the only way to cope with their limited cognitive resources and emotional problems (p. 482-3).

The Patsiokas (1979) subject group was not found to be more field dependent than the control group. However, the research does indicate that the younger the attempter the more likely he is to be field dependent. The age group marked by Patsiokas (1979), as young ages 19-34, has found to be more field dependent than was the rest of the subject group or the control group. Patsiokas (1979)

> The finding that suicide attempters are more field dependent than psychiatric controls in only this age group is important because it suggests that young attempters are different from older attempters. Young suicide attempters do not rely on their inner cognitions when coping with problems. Their function-ing is highly dependent on a stable environment; when this stability breaks down in a time of acute stress, a suicide attempt may become a feasible coping behavior since their problem solving abilities are inadequate (p. 483).

The subject group was not found to be more impulsive than the control group by testing. Patsiokas (1979) contends

> that support for the notion of impulsive behavior by suicidal attempters is given by the fact that 64.6% of them reported that their attempt was the consequence of an impulse to kill oneself. Another 23% indicated that their attempt was not thought out but decided during the day of the attempt (p. 483).

The report study indicates that impulsivity is more difficult to test than field dependency of cognitive rigidity, (as reported by the test group) and it is a more individual matter.

> Cantor (1976) studied the

> personality variables of affiliation (to prefer to be with friends rather than alone), nurturance (to help others when they are in trouble), succorance (to have others provide help when in trouble), endurance (to be nonimpulsive and to tolerate frustration in order to see things through to a possible conclusion), and aggression (to become angry and blame others when things go wrong) as they relate to the variables of attempted suicide and the frequency of suicidal thought (p. 325).

Cantor's test group consisted of 120 female college students. Twenty members of the group were found to have histories of one or more suicide attempts. The group was also divided into two sub-groups, one for low thinkers (those who gave little thought to suicide), and one for high thinkers (those who had more frequent thoughts about suicide).

Cantor (1976) hypothesized and substantiated three claims.

1) Those who have attempted suicide in the past have higher affiliative and succorant needs. They also have lower capacity for endurance and they externalize aggression.

2) Those who have attempted suicide have personality characteristics that most resemble those who think about suicide frequently.

3) Those who think about suicide frequently demonstrate succorant behavior, while attempters, highest in succorant need, demonstrate less succorant behavior than non-attempt groups (p. 325).

In analyzing the data it is apparent that attempters indicate a pronounced need to receive help from others but have a difficult time asking for help. Further data indicated that 40% of the high thinkers sought help from their mothers, 25% from their fathers and 24% felt they could seek out either parent. In low thinkers 46% indicated that they could seek out either parent. Cantor's study dealt with the internalization or externalization of anger at parents. All three groups, low thinkers, high thinkers, and attempters, stated that they preferred to externalize anger. An interesting note is that the highest preferance for externalization was among the attempters. An additional item asked the subjects' own feeling on their ability to withstand pain. The high thinkers and the attempters felt they had a lower pain threshold than the low thinkers.

Neuringer (1964) states that

> it is generally felt that the suicidal individual,
> because of his rigid modes of thinking, finds it dif-
> ficult to develop new or alternate solutions to
> deliberating emotional difficulties. Thus the individ-
> ual feels helpless and finds himself in a situation of
> "no exit" from an intolerably anxiety-laden situation
> and can only make his escape into death (p. 54).

Neuringer (1964) indicates that

> even if rigidity is not a full-blown characteristic
> of suicide attempters, the findings of the study have
> some implication for psychotherapeutic approaches with
> them. It is suggested that the therapist put a great
> deal of emphasis on helping the patient explore and
> widen his appreciation of the problem solving cir-
> cumstances available to him (p. 56).

The personality characteristics found to be consistent

among suicide attempters, as presented by Patsiokas (1979) and

Neuringer (1964) were cognitive rigidity (unable to think about

alternatives to problem situations), field dependency (dependent

on environment) and impulsivity. It was also found that those who

think about suicide alot resemble those who have attempted suicide

in their needs.

THEORIES OF SUICIDE

The founder of psychoanalysis, Sigmund Freud, was one of

the first to propose a theory of suicide. Litman and Tabachnick

(Resnik, 1968) identify that Freud

> suggested that the psychic energy for suicide had its
> origin in a death wish originally directed against someone
> else but now turned against the self, aimed at killing an
> object there (in the self) previously established by
> identification with someone in the past who had been
> loved and lost (p. 75).

> After 1920 Freud explained self-destructive behavior
> as the result of the intimate and constant interaction
> between two basic instinctual drives - Eros (the life

instinct) and the destructive instinct (the death instinct) within a complex, hierarchically organized psychic structure (p. 75).

According to Freud everyone is somewhat vulnerable to suicide because of general features of the human condition, such as the necessity for guilty compliance required of every member of the group by civilization which deprives each member of some possibilities for happiness, and the constant pressure of the death instinct with its clinical derivatives, the destructive instinct directed inward, and the aggressive instinct directed outward. Moreover, the extreme helplessness of the human ego in infancy is never completely overcome so that there always is a readiness under conditions of great stress and conflict to regress back to more primitive ego states. "It (the ego) sees itself deserted by all protective forces and lets itself die" (Resnik, 1968, p. 75).

Karl Menninger, himself a follower of Freud, agrees that suicide is the result of an internal conflict. Grollman (1971) lists the three hypotheses that Menninger presents:

"1) Wish to kill" (p. 34). As stated by Freud the individual has a wish to kill someone and in turn directs that aggression upon himself.

"2) Wish to be killed" (p. 34). "Just as killing is the extreme form of aggression, so being killed is the extreme form of submission" (p. 34). The individual has such a desire to suffer, to be punished, that they put themselves in the position of no exit.

"3) Wish to die" (p. 34). By dying the person believes that he/she will be able to free themselves from the emotional and mental turmoil they are under.

Menninger, as quoted by Litman and Tabachnick (Resnik, 1968) states his position:

> We propose now that there is in the suicidal determination
> an exposition of that deepest and most incomprehensible, yet
> inevitable, characteristic of man, his self-destructiveness.
> Freud repeatedly emphasized that the manifestations of the
> self-destructive instinct were never nakedly visible. In
> the first place, the self-destructive instincts get turned
> in an outward direction by the very process of life, and in
> the second place, they get neutralized in the very process
> of living. Self-destruction in the operational sense is a
> result of a return, as it were, of the self destructive
> tendency to the original object.... There are different
> kinds of suicides-we speak now not of the method used but
> of the motivation. There are accidental suicides, there
> are suicides which are substitutes for murder, there are
> suicides which are a cry for help, and suicides which are
> a miscarriage of an attempt to get oneself rescued. But
> some suicides are also expressions of total despair and
> ruthlessly directed at one's own self-annihilation. The
> essence of this ultimate form of suicide is that disente-
> gration of the ego and the overwhelming of the organism
> with self-directed destructiveness. It is the final and
> ultimate catastrophe of the organism (Resnik, 1968, p. 80).

Alfred Adler, in his theory of "Individual Psychology" presents suicidal behavior as the individual's feelings of inferiority. Grollman (1971), in his study of Adler, states,

> Suicide signifies a veiled attack upon others.
> By an act of self destruction, the suicidal person
> hopes to evoke sympathy for himself and cast reproach
> upon those responsible for his lack of self esteem
> (p. 35).

As viewed by Adler the suicidal individual is an "inferiority-ridden person" who punishes himself to hurt others.

A set of theories opposite to the psychoanalytic theories come from the social context camp. The pioneer in social context theory was Emile Durkheim. Durkheim felt that suicide and the cultural atmosphere were directly related. The individual act could be linked to how that person viewed society and how they felt they fit in.

It was Dirkheim's theory that there are three types
of suicide. Most suicides are egotistic. The person
has few ties with his community, and there is a relaxation
of religious, family, political, and social controls.
Self-destruction occurs because the individual is not
sufficiently integrated into his society. There is also
the anomic (anomie, meaning "lawlessness") suicide,
which represents the failure of the person to adjust to
social change. Such suicides may occur in times of
business crisis, such as an economic depression, or, in
an era of prosperity suicide may be committed by the
nouveau riche who is unable to adjust to a new standard
of living. Lastly, is the alturistic suicide, in which
the group's authority over the individual is so compelling
that the individual loses his own personal identity and
wishes to sacrifice his life for his community (Grollman,
1971, p. 34).

Many modern theorists on suicide have sought to integrate

the psychoanalytic theories with the sociologic theories. One such

research effort into this area has been taken on by Navrol (1969).

Navrol has attempted to connect many of the psychoanalytic dynamics

with the social surroundings and conditions.

Many of these psychoanalytic explanations of suicide
can readily be integrated with the sociological ones
just discussed by means of an examination of the emotional
implications of sociological contexts. Does a social
situation commonly involve the thwarting of one individual
by another? Does the thwarting mean such severe frustra-
tion by the thwarted person that in anger he would
strongly wish to kill the thwarter? If so, then according
to the generally held psychoanalytic view, that anger alone
might produce feelings of guilt about the wish to kill
strong enough to engender a wish to be killed. Finally,
without posting any "death instinct", does this thwarting
involve a social catastrophe of an apparently lasting or
long-term sort, such a catastrophe as might lead a person
to wish to die because life no longer seemed to offer its
usual satisfactions? (Krauss and Tesser, 1971, p. 220).

Navroll (1969) contends that a thwarted person, wronged by

someone or something in their environment, can generate the

amount of anger needed to wish someone dead and then turn that wish

upon themselves. Such psychological/sociological theories have

become the framework of crisis intervention work with suicidal families.

The three major theories of suicide fall into categories of:
psychological, sociological and combination of psychological and
sociological factors. The psychological theorist, led by Freud,
assert that suicide is the result of surpressed anger directed
internally. The sociological theories, presented by Durkheim,
contend that suicide is a result of the social condition. The
theorist who integrate the two schools of thought, such as Navroll,
put forth the idea that suicide is a result of psychological
dysfunction and sociological factors.

CRISIS INTERVENTION

During the last decade, the growth of the community
mental health movement has closely corresponded with the
development of innovative approaches to meeting mental
health needs in the community. An important part of
this trend has been increasing interest in crisis inter-
vention, a therapeutic approach developed from the
pioneering work of Lindemann, Caplan, and many others.
Crisis theory has now been extended and elaborated into
a soundly conceptualized and effective model for the
practice of brief therapy (Baldwin, 1977, p. 659).

Crisis intervention with families has been an increasingly
growing mode of treatment. In order to understand the framework of
crisis intervention one must first confront the myths which have
surrounded it. Baldwin (1977, p. 660) confronts several of these
myths.

"Myth: Crisis intervention is only for responding to
psychiatric emergencies." Psychiatric emergencies are a part of
crisis intervention but they occur on the far end of the spectrum.
The crisis as determined by the family may not be a psychiatric
emergency to the therapist but nonetheless it is of the utmost
importance to the family.

"Myth: Crisis intervention is a "one shot" form of therapy"
(Baldwin, 1977, p. 660). This myth limits crisis intervention to
only dealing with the initial stressful situation. Baldwin contends
that most crisis intervention ranges from one to eight sessions and
that the state of crisis for the family lasts from four to six
weeks.

"Myth: Crisis intervention is a form of therapy practiced
only by paraprofessionals" (Baldwin, 1977, p. 660). In the past,
crisis intervention became associated with "youth-oriented drug
crisis services staffed primarily by paraprofessionals." In the
development of youth drug lines and centers the word "crisis"
intervention was used to describe a wide range of skills and
techniques which were taught to, and used by, the staff. "However,
this type of crisis intervention contrasts with the soundly con-
ceptualized model developed for professionals by professionals over
the past three decades."

"Myth: Crisis intervention represents only a "holding
action" until longer-term therapy can begin" (Baldwin, 1977, p. 660).
The misconception here stems from the often held belief that crisis
intervention is only to hold the client over until they can see some-
one for real therapy. Often crisis intervention is only seen as
a supportive service and not as a therapeutic model. In some cases
intervention is designed as a supportive service to ongoing therapy,
or it can be used as a transistion to more long-term work. But, to
view crisis intervention in only those ways is to limit its potential.

In fact, crisis intervention is a soundly conceptualized
therapeutic model that provides an effective framework for
the practice of this form of brief therapy. As a result of

this recognition, crisis intervention has increasingly
been used as the treatment of choice for many patients,
for a large proportion of whom crisis intervention is
the only therapy required (Baldwin, 1977, p. 661).

"Myth: Crisis intervention is effective only for primary pre-
vention programs" (Baldwin, 1977, p. 661). Crisis intervention has
been shown to have an effect on the community on several different
levels. It has proven to be a multi-level tool.

"Myth: Crisis intervention does not produce lasting change"
(Baldwin, 1977, p. 661). During crisis the client, or family, is
at a peak level of motivation to change. It is at the time of
crisis when they seek out help that the family is most open to
change. Through the reaction to crisis and the process of resolving
crisis the client learns new behaviors.

"Myth: Crisis intervention requires no special skills for
the well trained therapist" (Baldwin, 1977, p. 661). To be
effective in a crisis intervention an additional set of therapy
skills is required.

Baldwin summarizes his beliefs toward the myths surrounding
crisis intervention:

> These often interrelated myths and misconceptions
> about crisis intervention have produced confusion, doubt,
> and ineffective use of this model among many mental health
> professionals who have been well-trained and who are quite
> competent. As this therapeutic model becomes more accurately
> perceived among professionals, its potential for helping and
> its application in various clinical contexts can only be
> enhanced (Baldwin, 1977, p. 662).

The development of family crisis intervention is a result of
two distinct movements in the mental health field. The first of
these two movements have been the trend toward brief therapy.
Pardes and Pincus in Simon Budman's book Forms of Brief Therapy (1981)

list several factors which have played a part in directing the attention of the mental health community toward brief therapy:

> *The acceptance of more limited therapeutic goals.
> *The increasing development of an array of varied treatments with a rapproachment of different therapeutic approaches.
> *Advances in classification of emotional disorders.
> *The growing realization that lengthy treatments often do not meet the needs of particular populations.
> *An increasing concern with the cost of treatment combined with increasing access to treatment.
> *The growth of prepaid health plans with limited psychiatric benefits.

> With regard to the acceptance of more limited goals, it became apparent that in a number of instances, long term psychological treatments did not have to be the recommended treatment for each and every person coming to a mental health practitioner. There were and are people who want relief from a specific symptom, help with a particular area of their personality functioning, improvements of their relationship with a certain person, and so forth, and there has been an increasing acceptance within the mental health provider community that such restriction of goals is consistent with a legitimate and important therapeutic enterprise (Budman, 1981, p. 12-13).

In viewing the duration of the crisis as ranging from four to six weeks, the idea of brief treatment is a feasible one. The theory of crisis intervention in brief therapy is rooted in the concept of goal-oriented service which uses several treatment techniques to solve the problem during the crisis.

The second movement in the mental health field which has contributed to the development of family crisis intervention is the move toward working with the entire family rather than the identified person. Some of the leaders of this movement have been Bowen, Whitaker, and Haley. Speck, in Resnik (1968, p. 342) explains the process of working with a family.

The family therapist explores the contributions of
the previous generations to each of the parents. The
influence of the past (family of origin) upon the present
(family of procreation) is studied and interpreted, and
abreaction of previous object losses and traumatic situa-
tions is encouraged. The marital relationship is examined,
and communication patterns and role relationships are
interpreted and subjected to discussion within the family
unit. Similar attention is focused on parent-child dyads,
on sibling dyads, or other significant groups within the
communication network of the family (Resnik, 1968, p. 342).

Through these two movements family crisis intervention

began to develop. Kaslow (1976, p. 316) has taken some initial

steps in identifying characteristics of people or families in

crisis.

Prominent characteristics of the crisis state are
feelings of helplessness, behavioral disorganization,
and cognitive confusion; a temporary rise of tension,
and signs of emotional upset such as anxiety, shame,
guilt, and depression; lowered efficiency in dealing
with daily tasks because energy goes into handling inner
tension, rather than to solving problems in the external
situation; an increased need for help from others, as well
as increased susceptibility to interpersonal influence.
It is exactly because of this heightened susceptibility
to influence that help should be immediately forthcoming
from that "caregiving professional" who is in the closest
position to offer it. When the need is extreme and
suitable help is provided, progress will be greatest
and deepest. During developmental periods of relative
calm, there is often little incentive for change (p. 316).

As the therapist begins to recognize crisis states and

characteristics, a framework for crisis intervention can be

developed. Baldwin (1977) states,

Crisis intervention as a model is neither a theory
of personality nor a comprehensive theory of psycho-
therapy. It is, rather, a limited but important frame-
work for responding to a normative life event: the
emotional crisis (p. 663).

As a model, crisis intervention cannot be viewed as a complete theory

such as psychoanalysis, behavior modification, gestalt, or relation-

ship therapy. The unique aspect of crisis intervention as a framework modality is that it allows the therapist to draw upon many varied techniques which may be effective with the family.

Baldwin (1977, p. 663) defines three levels of skills that the therapist must be adept at to work out of the framework of crisis intervention.

> In the course of professional training, the skills
> of the psychotherapist are essentially developed at
> three levels: 1) the conceptual skills that provide
> the framework for understanding patient problems and
> for developing strategies for change, 2) the clinical
> skills that are the techniques for implementing an
> effective therapeutic strategy and that are an extension
> of the conceptual framework, and 3) the communication
> skills that are necessary to enhance information
> exchange in the therapeutic relationship and to create
> a non-threatening, open relationship. Effective crisis
> therapy at each of these three levels requires a) the
> general skills of a well-trained clinician, and b) the
> special skills of the well-trained crisis therapist
> (p. 663).

The skills which are mentioned by Baldwin are as follows:

"1) Setting limits on therapeutic contracts" (p. 665). By setting time limits the therapist can set achievable goals which is the second point.

"2) Negotiating specific, achievable goals" (p. 665). The therapist needs to help the client focus in on short term realistic goals which the client can have some measure of success with.

"3) Focusing therapy on the present stress" (p. 666). In the crisis the family is motivated to work on the situation which has caused the stress, yet the family will often attempt to sidetrack the therapist when the issues become too intense. The task of the therapist is to keep the family focused on the presenting crisis.

"4) Accepting appropriate outcomes" (p. 666). The goal of the therapist should be to help the client "to reestablish a level of adaptive functioning on at least the pre-crisis level in the shortest period of time and at the least psychic cost" (p. 666).

"5) Becoming practical as a therapist" (p. 666). The therapist needs to become very problem-solving oriented and deal with the issues on a concrete level.

"6) Attaining skill in rapid assessment" (p. 666). With little time to evaluate the situation the crisis therapist must be adept at assessing the situation and introducing intervention strategies.

"7) Becoming more direct, but not directive" (p. 667). Because of the nature of the crisis state the therapist has to learn to become more active and direct in the therapy process.

"8) Managing difficult patients" (p. 667). The therapist must be prepared as they meet a family in crisis, especially those with suicidal youth, to be confronted with several different behaviors being manifested. The youth could be aggressive or withdrawn, the adults could be angry and out of control, or sobbing and out of control, or the siblings could be acting out some bizarre behaviors.

"9) Learning termination and disposition skills" (p. 667). Because the therapist is in and out within a few weeks they need to be adept at exiting from the family system.

Step by step models of crisis intervention are limited. Rusk, as presented by Beers and Foreman (1976, p. 87) maps out a sequence of counselor activities in crisis interviews.

Rusk proposes a seven step model for crisis intervention. His steps are as follows: (a) counselor presents self as a concerned, effective helper; (b) counselor focuses discussion on the client's affect and encourages its expression; (c) counselor explicitly empathizes with the expressed affect; (d) counselor gathers information about the crisis-inducing situation; (e) counselor makes a comprehensive statement formulating the clients problem(s) with which the client agrees; (f) counselor and client engage in exploration of potential strategies to improve or resolve the crisis-inducing stress; (g) counselor and client review the mutually determined strategy for the relief of stress and ways of dealing with future stress (p. 87).

The Beers and Foreman (1976) study showed that counselors who were not trained in Rusk model of crisis intervention did not significantly differ in their approach from those counselors who were trained in the Rusk model. The client report of success was similar in each group treated.

This study concludes that the Rusk model does not represent a unique approach to crisis intervention; rather, the model articulates sound interviewing practices for conducting crisis sessions (Beers and Foreman, 1976, p. 91).

A positive outcome of the Rusk model is that it provides the counselor with a map to follow as they progress which allows them to keep track of the therapy process.

As the therapist begins to assess the suicidal intent of the youth a direct yet caring approach is advised. When talking to a person at risk of suicide Motto (1978) suggests asking:

How persistant are such thoughts; how strong have they been; was much effort required to resist the idea? Have there been any impulses to carry them out? Have any plans been made? How detailed have they been? Have any preliminary actions been taken, such as collecting pills or obtaining a gun? When deterred the person? Does he or she think such feelings can be managed if they reoccur? Is there anyone the person can turn to at such times? Would they be able to call the counselor if they feel they can't control the suicidal impulse? (p. 540).

In recognizing the suicidal state of an adolescent one must also look at the family. Grollman (1971), "often he mirrors their emotional disturbances. The environmental situation could determine whether his potential for self-destruction becomes activated" (p. 77). Grollman continues,

> In a study of adolescents who had taken their lives, it was discovered that almost all the victims' mothers were themselves depressed and preoccupied with suicide. Also, the rest of the family might be influenced with anger and resentment. In order to vent their spleen, they unconsciously select one member to become the object of their accumulated aggression. Unfortunately he does not know how to cope with their malice. He cannot retaliate and respond appropriately. When he finally decides to take his life, he is really acting out the anti-social impulses of the family (p. 77-78).

This type of situation will occur when the family is in a state of crisis. The family has generated a tremendous amount of emotional energy during the crisis. The youth is the recipient of this misplaced energy and is scapegoated, in a manner of speaking. The youth often mobilizes this energy through suicidal behaviors. The suicidal behavior of the youth becomes the focal point of the family problem.

Haley (1981) presents eight items which should be addressed by the therapist who is beginning working with a family who has a problem young person in the home.

"1) The family should be told that the goal of the therapist is to get the young person back to normal as quickly as possible" (p. 116). Normal is defined as what is age appropriate for the child, which would either be that the child return to school or work. The therapy will be defined as brief and practical.

"2) The therapy will focus on the present situation rather than on the past" (p. 117). Many families are resistant because

they feel that counseling will drag out all the dark areas of their past. Important data from the past may be relevant but the issue is not to relive the past. The goal is to get the young person back to normal, the therapist must be consistant with the present.

"3) The goal of the therapy is to help the family solve its problems without having to put the young person into custody" (p. 117). Custody is only viewed as maintanence of the problem, it is not a solution.

"4) The therapist should emphasize that the best therapist for the young person are his parents" (p. 117). The parents know the child best, they can do more for them than any expert. In this way the problem is defined as a family problem rather than just viewing the young person as the problem.

"5) If the problem young person is of the troublemaking variety, at some point during the interview the father should be *asked if he can physically restrain the child*" (p. 117). If he does not think he would be able to, the therapist needs to have the father explore who else he could get to help him restrain the child. This statement helps put the parents in charge and also lets them know that the therapist realizes that the child's behavior is often hard to control and that this is a very difficult situation.

"6) If the young person is of the apathetic variety, the parents must be told that waiting for him to do something will not do" (p. 117). The parents must push the child to change, "when the parents insist, the young person knows they are ready for him to resume a normal life and can tolerate that" (p. 117).

"7) If the young person is suicidal the therapist might want to take the position that the family is to be responsible for

the young person's life" (p. 118). The family will need to take turns watching the child, or whatever else is needed. The family begins to change its structure as they mobilize their resources in helping the suicidal youth.

"8) The parents should be advised that it is very important for them to reach agreement on what the young person is to do" (p. 118). The question is not who is right or wrong, the goal is to pull the young person out of distress and help them straighten out.

A summary of family crisis intervention and treatment shows that it is a new phenomenon. The mental health community has slowly been dispelling the mythology which surrounds crisis intervention treatment and has begun integrating it into a framework of family therapy. The thrust of these two movements has been to treat the family at the time of crisis with a family centered model of therapy.

Chapter 3

DESCRIPTION OF PROGRAM UNDER STUDY

AND RESEARCH DESIGN

This study was designed to review adolescent suicide and how

family crisis intervention can help resolve the problem. This

chapter will delineate the Family Crisis Intervention Unit of Polk

County, Iowa, (FCIU) as a conceptual framework, as a program design,

and as an operational unit. Special attention will be given to

treatment assumptions.

Conceptual Framework

The conceptual framework for the FCIU is taken from a program

developed in Palo Alto County, California by Diane Sullivan Everstine,

Ph.D., Arthur M. Bodin, Ph.D., and Lewis Everstine, Ph.D. The

Emergency Treatment Center of the Palo Alto (herein after referred

to as ETC), has been developed to assist law enforcement, juvenile

justice programs, families, and individuals in the handling of

domestic crises. ETC is a mobile crisis intervention unit which

serves Palo Alto County. A mobile crisis intervention unit is a

unit which will leave the office and meet the client at the scene

of the crisis or at a neutral site.

The Palo Alto ETC provides crisis intervention counseling,

brief treatment, screening, referral and follow-through until other

services are established. The therapy is based on problem-solving

techniques which are utilized until an on-going service can be

tied into.

The FCIU of Polk County, Iowa, closely approximates the ETC model. The ETC model has placed a large emphasis on working with law enforcement. Arthur Bodin, Ph.D., has published several articles on working with law enforcement in domestic crisis ("Emergency Psychology: A Mobil Service for Police Crisis Calls." Family Process, 1977, 16(3), p. 281-292). In the development of the Polk County program much work was done with area police departments in assessing the community needs and the needs of the patrol officers. As with ETC, the emphasis of the FCIU is to provide crisis counseling, brief treatment, and referral.

The major differences between the Family Crisis Intervention Unit of Polk County and Palo Alto County's ETC are in the hours covered and number of counselors responding to the call. ETC provides for one person to be on call at any time, day or night, 24 hours a day, 7 days a week. FCIU allows for two counselors to be on call from 4:00 p.m. to 12:00 midnight 7 days a week. These differences will be further reviewed later in this chapter.

The FCIU was the major part of a large grant proposal for Polk County, Iowa, which was written in response to needs which arose from the revised Juvenile Code of the State of Iowa (1980). The grant proposal was written to attempt to secure monies within the state of Iowa Crime Commission which were set aside for juvenile justice programs. Iowa children and Family Services, the Child Guidance Center of Des Moines, and the Iowa Runaway Service were all actively involved in the writing of the grant. These agencies were working to provide a more comprehensive county-wide program of human services to juveniles and their families. The concept of the FCIU

is to provide a twenty-four hour service which will fill in the gaps
of the human service system of Polk County. As stated by Stephens
(1980), "The mobility of the FCIU and its brief treatment and
follow-through expertise will complete a holistic schema of services
to families within Polk County" (p. 3).

The grant was funded by the state of Iowa Crime Commission
and was purchased by Polk County. Polk County will provide addition-
al funds to the programs through 1982. At that time the Polk County
Board of Supervisors will determine whether to take on the additional
monetary responsibility for the programs or if the programs will be
discontinued.

Aside from the FCIU, money was provided for additional In-
Home Family Services through Iowa Children and Family Services, and
the Child Guidance Center of Des Moines. The Iowa Runaway Service
received funding to provide additional care facilities for out-of-
home juveniles. Through this joint funding several referral spots
are guaranteed for families seen by the FCIU.

Program Design

An overview of the FCIU published by the base agency, Iowa
Children and Family Services, states:

> The Family Crisis Intervention Unit, a program con-
> sisting of professionals trained in counseling and crisis
> intervention, works with adolescents, families, and
> individuals in their homes to relieve immediate crises
> and to initiate an active follow-up plan. The Family
> Crisis Intervention Unit works with other community
> agencies, as needed by the family in crisis. The Unit's
> primary effort is directed toward helping the family
> mobilize its own strengths to resolve its problems. It
> provides sympathetic attention and initiates necessary
> change with families in crisis. The purpose is to
> restore family esteem and equilibrium and, therefore,
> family functioning, and to reduce recidivism and

institutional dependence. Some crisis situations involve criminal acts and some do not. Counseling can be valuable in both kinds of cases. The unit will respond to a crisis, as defined by the family, when a request is made by the family or another agency for immediate outside intervention (IC & FS Publication, 1981).

The stated objectives of the FCIU are as follows:

*To reduce, by on-the-spot intervention, the seriousness of intense and possibly violent family crises;
*To relieve the police of some time-consuming involvement in crises which involve adolescents and families;
*To provide increased emergency and on-going community-based services to children and families as an alternative to removal for detention or shelter care;
*To facilitate shelter care or detention when necessary;
*To provide the screening, advocacy, and follow-up to families whose children are placed in emergency shelter when there is not another appropriate case manager;
*To reunite, when possible, previously beyond-parental-control adolescents with their families;
*To reach out to people in crisis who may be afraid or reluctant to seek the help they need on their own (IC & FS Publication, 1981).

FCIU is housed at the main office of Iowa Children and Family Services in Des Moines. IC & FS provides all clerical and additional office staff the program needs. The counselors of the FCIU staff are all Master's level personnel with experience in crisis counseling. The staff consists of one lead therapist, two full-time crisis therapists, and four half-time crisis therapists. The half-time crisis therapists split their time between the FCIU and the Family Counseling Program, and the In-Home Family Support Services of IC & FS. Three of the therapists split with Family Counseling, and one with In-Home. This split of the therapists' time makes possible the easy referral from FCIU to either on-going service, Family Counseling, or In-Home.

It is the responsibility of each crisis therapist to have their own transportation. The crisis therapist also has responsibility for the scheduling of their client follow-up visits, and the record keeping of all client contacts they have.

In its original operation, the FCIU took calls from 4:00 p.m. to 12:00 midnight. Because of the availability of funding this time was chosen to be covered. In researching the records of the Des Moines Police Department it was noted that the greatest number of domestic calls came during these hours. A two-member team of therapists would respond to the call. One of the two therapists would then in turn follow through with the case. A limit of thirty (30) days or six sessions is the maximum amount of time that can be spent with the family. There is no time limit set on the length of the separate sessions except limits that may be set by the therapist or the family. Follow-up with other community agencies who are presently involved with the family is extensive. The FCIU is careful not to duplicate services which are already being provided to the family. Following-up with clients and other resources maximizes the continuity of care.

Operation of Unit

The implementation of the unit was done according to the specifications indicated in the program design. As the unit progressed through the first nine months of operation it became apparent that a great number of crises were not being responded to immediately due to the number of hours during which the unit was not available. In response to this need, the FCIU went to the provision of a 24 hour service as of August 1, 1981. To make such a move the FCIU disbanded the team concept in favor of having one counselor on primary call,

and another counselor on back-up. Each shift worked by a counselor
is 24 hours. The primary counselor responds to all calls during their
24 hour shift. If a call comes in while the primary counselor is on
another call, the back-up counselor will receive the call and will
call back the family and let them know that the primary counselor
will get to them as quickly as possible. The back-up counselor is
also available to be used by the primary counselor as a consultant
or co-therapist on difficult calls. However, the main responsibility
of the back-up counselor is to respond to police emergency calls
when the primary counselor is already in service with a family. The
FCIU has agreed to respond to any police call for assistance in Polk
County on an immediate basis.

Before responding to a call the FCIU counselor will briefly
talk with the law enforcement officer or with one of the family
members and will get a brief description of the current status of
the situation. The counselor will ask such pertinent questions as:
Have there been any actual acts and/or threats of violence? Are any
weapons present? Is anyone under the influence of drugs and/or
alcohol? Is any family member in need of immediate medical attention
or placement? Is any extreme emotional and/or behavioral symptoms
being manifested? Who is presently at the scene? Who may be arriving
at the scene?

A major concern of the therapist is that they do not place
themselves in a dangerous situation. The FCIU has full cooperation
from local law enforcement in obtaining assistance and protection
during the crisis intervention.

Upon arrival at the scene the common mode of treatment is
to separate the family and speak with each person individually. This

allows the counselor to let each person know that their ideas, feelings, thoughts, and perceptions are important. This technique also gives the therapist a chance to gather important data before the family gets further involved in conflict. After meeting with each person the counselor will then bring the family back together and begin focusing on a common issue which the family will need to resolve if they are to relieve the crisis, at least for today. The therapy is very brief and goal oriented.

A unique aspect of the FCIU is that its policy is to follow-up with every family within 24 hours of the initial crisis visit. At this second meeting the counselor can get an idea as to the motivational level of the family. It is in this first follow-up interview that the counselor needs to begin to assess the merit of brief therapy for this family versus a referral to an on-going counseling service.

The FCIU works under a general set of assumptions when working with a family with a disturbed young person who may, or may not, be suicidal. These assumptions as stated by Haley (1981) are as follows:

1. It should be assumed that the hierarchy in the
family is in confusion and that there is a marital
impasse of more than usual severity. The way a
therapist begins the interview, even the matter of whom
he speaks to first, should begin to correct the hierarchy.

2. The problem person should be assumed to be
organically sound and intelligent, if only covertly so.
He or she is failing as a way of protecting the family
and should be approached with patience and respect,
but not allowed to disrupt the interview. Normality and
a medication-free life should be expected. The thera-
pist should express that view to indicate that the family
can survive normality.

3.   It should be assumed that the young person's leaving the family by becoming normal and self-supporting is a serious threat to the family, no matter how much the parents protest that that is their wish.

4.   The parents will offer the young person as the problem rather than the family. The therapist should accept this while knowing that the parents are also aware that the family is a problem (p. 114).

These assumptions are not always true. The benefit of them is that the therapist has some groundwork to start from in decoding the family system which has within it a suicidal youngster. If the therapist finds certain of these assumptions to be false he can disregard them without being bound by any of the family mythology, or any remaining mythology about suicide.

A major task for the FCIU therapist is to redefine the problem in terms of a family problem rather than an individual problem in a manner which the family will accept. Schneiner and Musetto (1979) give a case example of redefining the problem.

No longer were Steve's symptoms seen simply as a cause of family turmoil but were viewed as a consequence of family relational problems. His behavior was certainly a source of frustration to his parents and destructive to Steve, but, we asked them all to think of it as an attempt to be helpful to the family, i.e., as an example of negative loyalty (p. 196).

By redefining the problem the therapist can make a better assessment of whether the family can solve the crisis during the time frame of a maximum of 6 sessions, or if they need to be referred.

Research Procedures

The sample to be reviewed consists of those families who were seen by the FCIU between October 1, 1980, and September 30, 1981, who had an adolescent at risk of suicide. These families contacted the FCIU asking for crisis intervention.

The data which were collected pertain to: the duration of the initial crisis contact; the total amount of time spent on the case within the 30 day limit established within the design of the program; the number and percentage of families who accepted referral for on-going counseling. The data were collected by the author who is a crisis therapist employed by Iowa Children and Family Services in the FCIU. The data were taken from case notes on each family from the files at Iowa Children and Family Services and were hand tabulated by the author.

The data collected on the sample (families with an adolescent at risk of suicide), will be compared to the data collected on the general population (families in crisis but without an adolescent at risk of suicide). Additional information gathered on the sample includes: parental make up of the family; sex of the adolescent; and age of the adolescent.

Chapter 4

RESULTS AND DISCUSSION

This study consists of a review of the first year of

operation of the Family Crisis Intervention Unit (FCIU) of Polk

County, Iowa, specifically, the study reviewed the treatment of

families with an adolescent at risk of suicide.

This chapter will offer results of an examination of

statistical data gathered by the Family Crisis Intervention Unit

(FCUI) of Polk County, Iowa, during that Unit's first year of

operation, October 1, 1980 to September 30, 1981. The results

offered will be those which pertain to families who had an

adolescent at risk of suicide and who were seen by the FCIU. A

discussion of the results will follow the statistical presentation.

Results of the Study

During the FCIU's first year of operation a total of two

hundred eight (208) families were treated during crisis. Of this

number fifteen (15) of those families believed that at least part

of the crisis was being caused by an adolescent in the home who

was potentially suicidal. The task of this chapter will be to

delineate the amount of hours spent with each family during the

initial contact, the mean total hours spent on each case (all time

spent by the Unit on the family in direct or indirect hours), the

mean number of sessions per family, and the number of families who

chose to be referred to other agencies or individuals for on-going

40

treatment. The means of the sample group (those families who were seen by the FCIU who had an adolescent at risk of suicide) will be compared to the means of the general population (those families who were seen by the FCIU who did not have an adolescent at risk of suicide).

Table 1 reports the means for initial contacts and means for total hours spent on the cases.

Table 1

Mean Hours for Initial Contact and
Means for Total Hours Spent on Cases

	Mean Hours Spent on Initial Contact	Mean Total Hours Spent on Cases
General Population	2 hrs. 50 min.	6 hrs. 30 min.
Sample	3 hrs.	10 hrs. 15 min.

The means for the sample and the general population were not significantly different. The difference of the means of the total hours spent on the cases was significant. The difference of mean total hours spent on the cases was 3 hours 45 minutes.

Table 2

Mean Number of Sessions Per Family

	Number of Sessions
General Population	2.5
Sample	4.3

As can be seen in Table 2, the mean number of sessions differed between the two groups. As described in the program design, six sessions is the maximum number of sessions a family can be seen by the therapist.

Table 3 shows the number of families seen and the number and percentage of families referred.

Table 3

Number Seen, Numbers and Percentages of Families
Referred for On-going Treatment

	Total	Number Referred	Number Percentage Referred
General Population	193	79	41%
Sample	15	12	80%

Within the general population seventy-nine families out of a total of one hundred ninety-three treated, or 41%, chose to accept a referral for on-going treatment. Within the sample fifteen families, twelve, or 80%, chose to accept a referral for on-going treatment.

The data regarding the adults in the families having an adolescent at risk of suicide can be seen by examining Table 4, 5, and 6.

Table 4

Number of Families With Two Adults in the
Home Versus Single Adult Homes

Total N	Two Adults in Home	One Adult in Home
15	11	4

Table 5

Number of Families With Two Adults
in the Home

Total N	Two Biological Parents in the Home	One Biological Parent in the Home	Other
11	3	7	1

Table 6

Number of Families With Biological Mother
or Father in the Home

Total N	Biological Mother	Biological Father
15	15	3

As can be seen in Table 4, the majority of families in the
sample had two adults living in the home. However, as seen in Table
5, only three of the eleven two-adult families consisted of two
biological parents. The greater number of two-adult families consist
of at least one step-parent. The additional family listed as "other"
in Table 5 consisted of one biological parent and the maternal
grandfather who had always resided with the family. An interesting
statistic, as shown in Table 6, is that in all fifteen families in
the sample the biological mother lived in the home while only three
biological fathers lived in the home.

Table 7 represents the data regarding sex, age range, and
mean age for adolescents at risk of suicide.

Table 7

Sex, Age Range, and Mean Age

	Number	Age Range	Mean Age
Female	7	13-16	14.5
Male	8	12-17	15

There was no significant difference in the sex of the
adolescents at risk of suicide. The age range and mean age are
similar. However, in compiling the results it was noted that the
youngest attempter was a 12 year old male, which contrasted with the
rest of the male attempters who ranged mostly from 15-17. Female
attempters were evenly spread out across the age range.

DISCUSSION

The data collected in this study indicated that the hours
spent in the initial contacts for suicide crisis calls and non-
suicide crisis calls were not significantly different. However,
a significant difference was found in the total amount of hours
spent on the cases in the sample versus the general population
cases. This difference, 10 hours fifteen minutes for the sample as
compared to 6 hours 30 minutes for the general population, indicates
that the adolescent at risk of suicide cases required more therapist
effort. This effort can be attributed in part to the additional
resources that the therapist may have had to coordinate. Another
reason for this significant difference could have been the amount
of involvement the people in the family had in this type of crisis.

It can be assumed that an adolescent at risk of suicide would tend to mobilize the family to take extensive actions to resolve the problem.

The assumption that families with an adolescent at risk of suicide are more mobilized and involved in the treatment can be supported by the fact that none of the families seen by the FCIU with an adolescent at risk of suicide dropped out of treatment prematurely. The mean number of sessions was significantly higher for the sample than for the general population. Of the fifteen sample families seen by the FCIU twelve families chose to accept referral on the therapist's recommendations. The three remaining families in the sample felt that after the six sessions that the problem had been resolved. The 80% referral and the 20% problem-resolved figures give the FCIU a 100% success figure in meeting two of the main objectives of the program: 1) reducing the seriousness of intense and possibly violent family crises, and 2) providing screening, advocacy and follow-up.

As shown earlier the greater majority of families had two adults in the home. Of these eleven families only three had both biological parents in the home. These three families which had both biological parents in the home also contained the only biological fathers in the sample. In all fifteen families the biological mother was in the home. An interesting sidelight was that in three of the single adult homes there was another significant adult who took a psuedo-parent role even though they did not live in the home.

Of the fifteen families who reported an adolescent at risk of suicide, three families had previously hospitalized the adolescent for the same presenting problem. In three families one of the

biological parents had previously been hospitalized for suicide intent. Given these figures, six families had previously attempted hospitalization to solve the problem and this time had turned to an alternative treatment. Also, two families reported that a significant person from within the family had committed suicide within two years of the present crisis.

During the crisis interview, two families conveyed the fact that on that same day the youth had made an attempt on his/her life. Five families felt that the youth had planned a suicide attempt and had acquired the instruments they needed to follow through with the action. None of the adolescents stated that on that day they had planned to take their life. All fifteen adolescents did communicate to the therapists that they had thought about suicide more than once.

The problem, as stated by all fifteen sets of adults living in the homes, was caused by the adolescents. Conversely, the problem as expressed by all fifteen adolescents was that there were many problems in the family, and many problems in their personal lives which were leading them to think about the possibility of suicide.

One additional piece of information is the fact that during the year this study was reviewed, none of the adolescents at risk of suicide who were seen by the FCIU committed suicide. This data indicates the success of the FCIU treatment modality.

Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study has been to review the first

operational year of the Family Crisis Intervention Unit of Polk

County, Iowa (FCIU), in treating families with an adolescent at

risk of suicide. The study grew out of the researcher's experience

of being one of the therapists for the FCIU and an interest in the

prevention of suicide. The impact of an adolescent's death on the

family can be, and usually is, devastating. The goal of the FCIU

in these cases is to prevent a death by intervening at the time of

crisis and involving the family in a treatment process.

The case files for the year October 1, 1980 to September

30, 1981, were reviewed by the researcher. The research hand

tabulated mean hours for initial contact, mean total hours spent on

cases, mean number of sessions per family, and the number and

percentage of families who chose to accept a referral for on-going

services on the therapist's recommendations. Additional information

was gathered concerning the sex, age range, and mean age of the

adolescents at risk of suicide. Also, family data on the sample -

families with an adolescent at risk of suicide - was delineated.

Present and past literature on suicide myths, suicide motives

and states, personality characteristics of suicide attempters, and

theories of suicide were presented. The literature reviewed also

47

pertained to family crisis intervention. The presentation of the FCIU as a program design was included.

The findings as discussed in Chapter 4 were: the mean hours for initial contact did not differ between the sample and the general population. The mean total hours spent on sample cases was significantly larger. The mean number of sessions per family was greater in the sample than in the general population. The referral percentage was significantly larger in the sample.

In reviewing family information it was found that the majority of families in the sample had two adults in the home. In the sample the biological mother lived in the home in every case. The problem as presented by the adults in the sample was focused on the adolescent. All the adolescents in the sample focused the problem on the family. From these findings and discussion the following conclusions and recommendations have been reached.

Conclusions

The following conclusions have been reached on the basis of this study:

1) The program design of the Family Crisis Intervention Unit of Polk County, Iowa (FCIU), as an operational unit has been effective. The effectiveness has greatly increased as of August 1, 1981, when the FCIU expanded it's services to cover 24 hours, 7 days a week.

2) The treatment modality of the FCIU has been effective in treating families with an adolescent at risk of suicide.

3) The high referral rate in the sample has shown that the FCIU has done a good job of reframing the identified problem and getting families to accept referral for on-going services.

4) Cases seen by the FCIU with an adolescent at risk of suicide require more therapist effort.

5) Families with an adolescent at risk of suicide are more involved in the treatment process.

Recommendations

These recommendations have been reached at the conclusion of this study:

1) The Family Crisis Intervention Unit of Polk County, Iowa, continue present operational procedure in responding to crisis calls.

2) The FCIU continue present treatment modality in treating families with an adolescent at risk of suicide.

3) The FCIU do six month follow-ups with the families with an adolescent at risk of suicide to assist the families with further services if needed and to get feedback from the families on possible program changes.

4) The FCIU should increase community knowledge of the program though "Public Service Announcements."

5) The FCIU should develop a review procedure to review the second operational year October 1, 1981 to September 30, 1982 and subsequent years.

BIBLIOGRAPHY

BIBLIOGRAPHY

Baldwin, Bruce A. "Crisis Intervention in Professional Practice: Implications for Clinical Training." American Journal of Orthopsychiatrists, 47 (4), October 1977. pp. 659-669.

Beers, Jr., Thomas M. and Foreman, Milton E. "Intervention Patterns in Crisis Interviews." Journal of Counseling Psychology. 1976, Vol. 23, pp. 87-91.

Bowen, Murray. Family Therapy in Clinical Practice. New York: Jason Aronson, London, 1978.

Budman, Simon H. Forms of Brief Therapy. New York, London: The Gulford Press, 1981.

Cantor, Pamela C. "Personality Characteristics Found Among Youthful Female Suicide Attempters." Journal of Abnormal Psychology, Vol. 85, No. 3, 1976. pp. 324-329.

Carter, Elizabeth A., McGoldrick, Monica. The Family Life Cycle; A Framework for Family Therapy. New York: Gardner Press, Inc., 1980.

Clarkin, John F., Frances, Allen J., Moodie, James L. "Selection Criteria for Family Therapy." Family Process, Vol. 18, December 1979. pp. 391-403.

Family Crisis Intervention Unit. Publication of Iowa Children and Family Services. 1981.

Farberow, Norman L., McEvoy, Theodore L. "Suicide Among Patients with Diagnosis of Anxiety Reaction or Depressive Reaction in General Medical and Survical Hospitals." Journal of Abnormal Psychology, Vol. 71, No. 4. pp. 287-299.

Goldberg, Martin and Mudd, Emily H. "The Effects of Suicidal Behavior Upon Marriage and the Family."

Grollman, Earl A. Suicide. Boston: Beacon Press, 1971.

Haley, Jay. "Leaving Home. The Therapy of Disturbed Young People." McGraw-Hill, 1980.

Kaslow, Florence. "Crisis Intervention Theory and Technique." Intellect, January 1976. pp. 316-318.

King, Muriel. "Evaluation and Treatment of Suicide - Prone Youth." Mental Hygiene, Vol. 55, No. 3, July 1971. pp. 344-351.

Krauss, Herbert H. and Tesser, Abraham. "Social Contexts of Suicide." Journal of Abnormal Psychology, Vol. 78, No. 2, 1971. pp. 222-228.

Kreider, Douglas G. and Motto, Jerome A. "Parent-Child Role Reversal and Suicidal States in Adolescence." Adolescence, Vol. IX, No. 35, Fall 1974. pp. 365-370.

Krell, Robert and Rabkin, Leslie. "The Effects of Sibling Death on the Surviving Child: A Family Perspective." Family Process, Vol. 18, December 1979. pp. 471-477.

Litman, Robert E. (Ed.) Proceedings 6th International Conference for Suicide Prevention. 1972.

Miller, John P. "Suicide and Adolescence." Adolescence, Vol. X, No. 37, Spring 1975. pp. 11-23.

Motto, Jerome A. "Recognition, Evaluation, and Management of Persons at Risk for Suicide." Personnel and Guidance Journal, May 1978. pp. 536-543.

Neuringer, Charles. "Rigid Thinking in Suicidal Individuals." Journal of Consulting Psychology, Vol. 28, No. 1, 1964. pp. 54-58.

Patsiokas, Anne T., Clum, George A. and Luscomb, Richard L. "Cognitive Characteristics of Suicide Attempters." Journal of Consulting and Clinical Psychology, Vol. 47, No. 3, 1979. pp. 478-484.

Resnik, H. L. P. Suicidal Behaviors. Boston: Little Brown and Company, 1968.

Ruereni, Uri. "Family Network Intervention: Healing Families in Crisis." Intellect, May-June 1976. pp. 580-582.

Scheiner, Lilian C. and Musetto, Andrew P. "Redefining the Problem: Family Therapy With a Severely Symptomatic Adolescent." Family Therapy, Vol. VI, No. 3, 1979. pp. 195-203.

Skodol, Andrew E., Kass, Frederic, and Charles, Edward. "Crisis in Psychotherapy: Principles of Emergency Consultation and Intervention." American Journal Orthospychiatrists, 49 (4), October 1979. pp. 585-597.

Smith, Donald F. "Adolescent Suicide: A Problem for Teachers?" Phi Delta Kappan, April 1976. pp. 539-542.

Speck, Ross V. "Family Therapy in the Home." Journal of Marriage and the Family, Vol. XXVI, No. 1, 1964. pp. 72-76.

Stephens, Doug. "Family Crisis Unit Proposal. Iowa Children and Family Services." 1980.

Stone, Howard W. Suicide and Grief. 1972.

Weakland, John H., Fisch, Richard, Watzlawick, Paul and Bodin, Arthur M. "Brief Therapy: Focused Problem Resolution." Family Process, Vol. 13, No. 2, June 1974.

Wenz, Friedrich V. "Sociological Correlates of Alienation Among Adolescent Suicide Attempts." Adolescence. Vol. XIV, No. 53, Spring 1979.