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Child and adolescent suicide: A perspective for the elementary school guidance counselor

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Abstract

The elementary school guidance counselor is in a unique position to assist in the identification of young people who are at-risk or potential suicide casualties. The counselor can enhance this identification by alerting the school population (administrators, teachers, staff, and students) to the dynamics of suicide among young people (Deykin, 1984). Suicide implies a total turning away from life itself showing the inability or refusal to accept the terms of human development, both physically and emotionally (Maris, 1981). The elementary counselor must be aware of suicide not only from its tragic consequences but from the standpoint of positive prevention. The counselor needs to increase his/her knowledge of suicide including current statistical information, suicide myths, suicide antecedents, intervention strategies, and prevention strategies.

Child and Adolescent Suicide: A Perspective for the Elementary School Guidance Counselor

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The elementary school guidance counselor is in a unique position to assist in the identification of young people who are at-risk or potential suicide casualties. The counselor can enhance this identification by alerting the school population (administrators, teachers, staff, and students) to the dynamics of suicide among young people (Deykin, 1984).

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The elementary counselor must be aware of suicide not only from its tragic consequences but from the standpoint of positive prevention. The counselor needs to increase his/her knowledge of suicide including current statistical information, suicide myths, suicide antecedents, intervention strategies, and prevention strategies.

Statistical Information

The need for counselor awareness becomes evident once the statistics are digested. Suicide for adolescents has increased by three hundred percent during the years 1957-1975 (Fujimura, Weis, & Cochran, 1985; Ray & Johnson,

1983) and by four hundred percent for the years 1962-1982 (Wellman, 1984). An increase of two hundred fifty percent to three hundred percent is cited for 15-24 year olds during the period 1961-1981, (Johnson, 1985) and verified during the period 1957-1982 (Hendin, 1982). The 10 year period 1965-1975 reports a twenty-four percent increase (McBrien, 1983) and the 20 year period 1960-1980 showed a one hundred seventy-one percent increase (Johnson, 1985) for individuals 15-19 years old. A 10 year study, 1968-1978, for 10-14 year olds showed an increase of thirty-two percent in the suicidal rate (McBrien, 1983).

The same dramatic increase is illustrated when the statistics are viewed based on the number of young people who commit suicide per 100,000 of their population. In 1957 there were 4 adolescents per 100,000 who committed suicide, in 1974 the number increased to 10.9, and in 1975 the increase reached 12.2 (Ray & Johnson, 1983; Fujimura, Weis, & Cochran, 1985). For 15-24 year olds the increase ranged from 8.8 (1970) to 12.3 (1980) (Mercy, Tolsma, Smith, & Conn, 1984). In 1976, 15-19 year olds had a 5.5 rate (Hipple & Cimbolic, 1979) as compared to 1978 when the rate advanced to 7.64 (Shaffer & Fischer, 1981). The 10-14 year olds, in 1978, had a .81 rate (Shaffer & Fischer, 1981) but increased to 1.0 in 1980

(Matter & Matter, 1984) while the 5-15 year olds, 1976, had a 0.2 rate (Hipple & Cimbolic, 1979). In 1978 children under 12 showed few suicides (Shaffer & Fischer, 1981) which is evidenced by a number of 1 or 2 per million committing suicide (Kosky, 1983).

Statistics do not show the number of attempted suicides, which has been estimated to be 1 per minute for 10-12 year olds in 1976 (Hipple & Cimbolic, 1979) or 10 times the actual suicide rate for the entire population (Morgan, 1981). They also do not illustrate the number of suicides that are considered accidental, unreported, or covered up (Shaffer & Fischer, 1981). Based on the statistics it is clear that suicide is on the increase and must be dealt with immediately.

Definitions

Suicide involves an intent to die and a deliberate act inducing death (de Catanzaro, 1981). Suicidal intent can be measured by the degree to which the individual wishes to end his/her life (Deykin, 1984). Lethality can be measured in terms of the deadliness of the suicidal act (Wekstein, 1979).

Mandle (1984) defines suicide as a voluntary act causing one's own death and this act is self-decreed,

intended, and hoped for.

Two key elements are always present in all definitions: intent and lethality.

Attempted suicide contains the same key elements of suicide; the only difference being the act was unsuccessful (Wekstein, 1979). It should be noted that in some cases classified as attempted suicides are not that at all. The individual did not have the intent to die and purposely arranged events in such a manner as to survive and only gave the appearance of intent to die (de Catanzaro, 1981).

Suicide Myths

Suicide carries with it a great deal of folklore. The counselor should become acquainted with the myths surrounding suicide in order to accurately confront the problem.

"Adolescence is a trouble-free time of life." On the contrary, this period of growth is marked by rapid changes in physical and emotional development (Wekstein, 1979; Ray & Johnson, 1983).

"Adolescent suicide prevention programs will instill the idea of suicide in the student" (Johnson, 1985). This idea is totally unfounded in the literature.

"It is dangerous to discuss suicide with a person who seems depressed." It would be better to say it is dangerous not to discuss suicide with a person who seems depressed (Johnson, 1985).

"If you don't talk about it, it will go away. If you get someone to talk about suicide, it will plant the idea in their head and if they commit suicide it is your fault." On the contrary, the individual will feel a sense of relief, safer, and more secure after discussion (Davis, 1985; McBrien, 1983).

"A certain type of individual commits suicide." Suicide shows no favoritism regarding age, sex, race, region, or socioeconomic status (Morgan, 1981; Deykin, 1984; Ray & Johnson, 1983).

"Once a person has attempted suicide and failed, the guilt and shame will keep the person from trying again." The reverse is true since the person has crossed from thought to action and further attempts will be easier (Johnson, 1985).

"Suicidal behavior is contagious or hereditary" (Davis, 1985; Choron, 1972).

"Suicidal people are fully intent on dying." Choron (1972) and Ray & Johnson (1983) conclude that they are undecided and are communicating a cry for help.

"Improvement following a suicidal crisis means the suicidal risk is over." The three month period following first signs of improvement is the time period most suicides occur (Wekstein, 1979; Ray & Johnson, 1983).

"Once a person is suicidal, he is suicidal forever." The suicidal crisis is of short duration (Wekstein, 1979; Ray & Johnson, 1983) and can be overcome with support, understanding, and caring on the part of the significant other.

"Those people who talk about committing suicide never do." In most cases the act is impulsive and a reaction to a stressful situation. Talking about suicide is a cry for help (Wekstein, 1979; Ray & Johnson, 1983).

Many adults and students believe the above myths to be true. An important role for the counselor is to refute these myths if he/she is to be able to counsel, coordinate, and consult in the area of suicide.

Suicide Antecedents

A young person may chose suicide instead of other alternatives. Justifications cited in the literature include the following: 1) parents and family relationships; 2) peer conflicts and relationships; 3) school pressure

and problems; 4) depression; 5) escape; 6) loss; 7) feelings (rejection, lack of love, anger, revenge, hopelessness, and poor self-image) (Pinkston, 1983; McBrien, 1983; Kosky, 1983; Hals, 1985; Choron, 1972; Mandle, 1984; Davis, 1985; Brooke, 1974; Bernhardt & Praeger, 1985; and Pfeffer, 1981).

The basic cause of suicide relates to a lack of coping skills when the youth is confronted with situations of stress. Suicide is an act of depression, a reaction to hopelessness, or an adaptation on the part of the individual. The person feels incapable of coping with present circumstances and expects little improvement in the future (de Catanzaro, 1981). Two basic conditions are present: strong increasing stress and a diminishing ability to cope with problems (Pretzel, 1972).

Warning Signs

The counselor, as well as administrators, teachers, staff, parents, and students, should be familiar with the five basic warning signs of a potential suicide. First, a suicide threat or other statements about suicide and death has been communicated. Second, a previous suicide attempt has been made. Third, the individual has been suffering from prolonged depression. Fourth, marked

changes in behavior and/or personality have been exhibited. And fifth, the individual making final arrangements or putting things in order (Davis, 1985).

Other warning signs to be noted by the counselor and significant others are: family strife, loss of a love object, difficulties in school, rebellious attitude, decreased involvement in activities that were at one time fun, decreased communication, feelings of helplessness and hopelessness, increased alcohol and drug abuse, giving away prized possessions, ambivalence, recent loss of a loved one to suicide, atypical sleeping and/or eating habits, and verbal communication of feelings of worthlessness, isolation, and failure (Wellman, 1984; Morgan, 1981; Ray & Johnson, 1983; Deykin, 1984; Renfro, 1985; McBrien, 1983; Johnson, 1985; and Pretzel, 1972).

After viewing suicide antecedents and warning signs a composite of the potentially suicidal child can be attempted. The child is likely to have experienced an unpredictable family life from an early age. The child possesses inadequate communication skills and poor coping skills. Intense anger and antisocial behavior tend to be present. And finally, the child lacks skills to effectively handle stressful situations. The theme seems to center on increasing stress coupled with repeated loss (Matter

& Matter, 1984).

The implication is that suicide can be prevented by teaching the child better coping and problem-solving skills and by involving the entire family in therapy (Matter & Matter, 1984).

Intervention

When a potential suicide situation is brought to the counselor's attention he/she must act by seeing the student immediately and showing the student support through active listening (Wellman, 1984). At this point, the primary concern is to help the student see alternatives and regain some control over his/her life (Fujimura, Weis, & Cochran, 1985).

Should the counselor feel the situation is too much for him/her to handle effectively, referral is necessary. It is important that the counselor know how, when, and where to refer students whose concerns fall beyond the counselor's expertise. When in doubt, refer.

The counselor may use a contract if it is determined that a suicide threat is likely. The contract needs to be specific and contain an agreement not to kill one self for a certain period of time (usually from session to

session), a directive to rid and turn over to the counselor any potentially dangerous items (means for suicide), and the home and office phone numbers of the counselor to enable 24 hour contact (Fujimura, Weis, & Cochran, 1985).

Objectives of the counselor in helping a student through a crisis situation should include: 1) a willingness to be deeply involved in a caring yet firm manner; 2) to be available to the student 24 hours a day; 3) to determine if the student has the means to complete the suicidal act and if so, ask for them; 4) to remain with the student if the danger of suicide is imminent; 5) to use a contract; 6) to instill hope; 7) to help the student realize his/her irrationality of thinking; 8) to help develop a support system for the student which could involve parents, friends, peers, family members, and clergy; 9) to help alleviate stress; and 10) to maintain an involvement with the student for the duration of the crisis and prolonged situation (Morgan, 1981).

Assessment

In assessing suicidal potential and intent Hawton & Catalan (1982) recommend that the counselor consider the student's family and personal history background, coping

skills including past coping attempts and current coping resources, present mental state, current problems, and establishing what further assistance may be required.

Deykin (1984) provides the counselor with a series of graded questions designed to assess intent first and lethality second. As the student advances through the questions, by affirmitive responses, his/her risk potential, intent, and lethality increases. The questions begin with general feelings toward life and progress to more specific feelings and attitudes toward suicide completion.

Another assessment tool involves the use of 16 basic questions designed to quickly provide the counselor with key elements as to why the crisis occurred and what the counselor can do to help resolve it (Getz, Allen, Myers, & Linder, 1983).

Beck's Scale for Suicide Ideation operates as a continuum comparing the student's will to die to his/her will to live. The questions concentrate on four areas: 1) attitude toward dying; 2) attitude toward living; 3) characteristics of suicidal thoughts; and 4) actual suicide plans (McBrien, 1983).

Directly focused on the cognitions of the student are a series of 10 questions developed by the Center of Cognitive Therapy (McBrien, 1983). (See Appendix)

In assessing the situation the counselor is attempting to quickly find all pertinent information in an orderly fashion so as to gauge the student's potential for suicide. From this point the counselor can then decide "where the student is at" and whether to refer if the situation is beyond his/her expertise or whether to continue counseling the student (McBrien, 1983). In so doing the counselor is obtaining the necessary information, evaluating the suicide potential, clarifying the nature of the stress and the problem, and assessing the student's strengths and resources (Fujimura, Weis, & Cochran, 1985).

Assessment of suicidal risk can only be done by direct communication with the student which involves a willingness to ask frank questions and to hear some disquieting responses (Deykin, 1984).

Treatment

In general, but related to the potential crisis situation, counseling has as its goals affording the student an opportunity to discuss or talk about his/her problem, helping the student cope with stress in a crisis situation, and helping to develop a plan for coping with daily demands (McBrien, 1983).

The counselor attempting to help build new coping skills with the student can and should involve the family so that all can learn better methods of communication, problem solving, and coping skills. Concurrently, the counselor helps to alleviate stress for the student, communicates empathetic understanding of the student's feelings, and affords the student a stable, continuing relationship (Matter & Matter, 1984).

Stephen H. Glenn (as cited in Renfro, 1985) suggests a 7 step plan for building strong, capable individuals. For the student to perceive him/herself as capable he/she must set realistic goals and expectations, develop responsibility and accountability for his/her behavior, and have confidence in his/her personal resources to solve problems. Through the development of personal (self-discipline, control, and assessment), interpersonal (communication, empathy, and sharing), systematic (decision making and problem solving), and judgemental (recognizing, understanding, and applying knowledge) skills the individual can begin to develop as a capable person (Renfro, 1985).

The purpose of the counseling relationship is to reduce and eventually stop self-destructive acts and to assist the student in developing new and better means of coping. This is brought about by the counselor actively conveying his/her

interest in the student's well-being, showing understanding, and establishing hope. In addition, the counselor stresses to the student that change is expected, the counselor will be constantly available, and he/she will aid the student in the process of change (Hipple & Cimbolic, 1979).

Supplemental to and operating concurrently with the counseling process is the student's life line. The life line is composed of the student's significant others with the purpose of providing the student with someone to hold on to in time of suicidal crisis (Hipple & Cimbolic, 1979).

The counselor's expertise in functioning during a suicidal crisis or potential suicidal situation must include recognizing (responding), evaluating (determining lethality), intervening (restoring hope), and following through (keeping communication open) (Hosier, 1978).

Prevention

The goal of prevention is to intervene before the student has reached the point of acting out or committing the suicide (McBrien, 1983). Ideally, the counselor is entering the situation at a time when he/she can help the student cope with the stresses resulting from their problems before the situation deteriorates beyond the point of no

return (Fujimura, Weis, & Cochran, 1985).

Suicide is a preventable act if educators and the public can identify the "at-risk" youngsters and provide appropriate help (Deykin, 1984).

Counselors can provide better service to the school population by creating a communication network which keeps them informed of students experiencing a life crisis (McBrien, 1983). The personnel network should be composed of any and all people who are in regular contact with the school population (Ray & Johnson, 1983). This will include school personnel such as administrators, teachers, and staff, along with parents, friends, and peers.

Teachers are in an excellant position to aid the counselor since they are often considered neutral parties who are safe, stable individuals who can be approached by the student population (Pinkston, 1983). As a result of their accessibility to the student population teachers need to know suicide's warning signals, have an understanding of suicide and depression in young people, have an acceptance for the warning signals as a cry for help and have a knowledge of appropriate courses of action to take should the need arise (Johnson, 1985).

Primary prevention involves educating and informing school personnel and parents to recognize, identify, and

assess suicide potential. The idea that love, concern, and skill can make the difference is emphasized by Renfro (1985) and Davis (1985). In addition to the school staff, the counselor must involve and inform the student population to enable the students to become more sensitive to one another and their needs (Davis, 1985).

The teacher can be a facilitator leading discussions on depression and self-destructive behavior. Through discussion groups students increase their self-awareness and realize that their innermost feelings are not unique, that others have similar thoughts and feelings, that there are many ways to cope with one's feelings and problems, and that they too can help recognize and understand depression and suicidal behavior in others (Johnson, 1985).

The counselor, through workshops and in-service meetings, can provide the teacher with guidelines in leading such discussions. The guidelines might include: 1) understanding your own feelings of suicide; 2) establishing communication with students; 3) reinforcing to students the fact that you care; 4) explaining confidentiality; 5) being aware of changes or stresses in students' lives; 6) reaching out to all factions of the student population; 7) looking for signs of coping difficulties; 8) not hesitating to ask for outside help; and 9) providing support to the students

(Vinci, 1985).

Students can help themselves and others in the following ways: 1) recognizing warning signals; 2) getting professional help; 3) talking about suicide; 4) telling the person "I care!"; 5) letting the person see alternatives and choices; 6) getting the person help; 7) helping the person find one reason for living; 8) convincing the person that death is final and irreversible; 9) being accepting; and 10) being nonjudgemental (Hals, 1985).

Implications for the counselor include the counselor having the skill to relate to the student in a clear and empathetic manner, understanding the factors associated with childhood suicide, developing interaction of services between the school and other agencies, knowing one's own attitudes and skills, and being willing and able to refer a child if in doubt (Pfeffer, 1981).

Conclusion

The child's life experiences coupled with school experiences and their subsequent stressful situations, can be too much for the child to cope with or handle effectively. The counselor's goal is to help the student cope successfully in these situations thus preventing an

incidence of suicide.

The effort to help a suicidal individual is extreme and emotionally draining but not nearly as burdensome as losing a student to suicide (Deykin, 1984).

The counselor, staff, and parents are in a position to help young people alleviate stressful situations from their school experience. Dick Lowry, speaking at the University of Northern Iowa, April, 1985, put the attitude in perspective by stressing that adults not worry so much about the grades a child is receiving but rather be interested in the person the child is becoming.

Appendix

Ten Critical Questions

The ten critical questions developed by the Center of Cognitive Therapy are:

1) How will you do it?
2) How much do you want to die?
3) How much do you want to live?
4) How often do you have these thoughts?
5) When you are thinking of suicide, how long do the thoughts stay with you?
6) Is there anyone or anything to stop you?
7) Have you ever attempted suicide?
8) Do you have a plan?
9) On a scale of 1 to 10, what is the probability that you will kill yourself?
10) What has happened that makes life not worth living?

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