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AUTHOR	Frederick, Calvin J.
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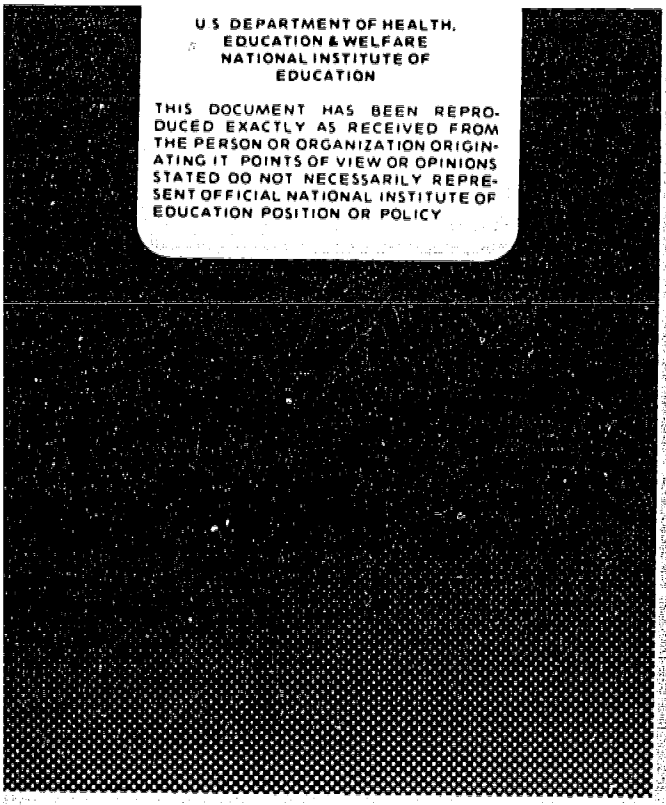
ABSTRACT

The pamphlet discusses methods of recognizing and responding to behavior that can culminate in suicide, with emphasis on adolescents and young adults. Incidence and types of behavior--self-assaultive, self-destructive, and suicidal--are described, clues to aid in the identification of potential suicides are provided, and ten preventive steps are recommended. (IM)

National Institute of Mental Health

TRENDS IN MENTAL HEALTH

Self-Destructive Behavior Among Younger Age Groups



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2

Dr. Calvin J. Frederick, Chief of the Disaster and Emergency Mental Health Section, National Institute of Mental Health, discusses methods of recognizing and responding to behavior that can culminate in suicide—a leading cause of death among young Americans.

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Various forms of self-destructive behavior among youth, including suicide, have continued on an alarming course in recent years. The suicide rate has almost doubled among young males in the younger age groups over the last decade. The figures have risen from 6.3 to 11.0 per 100,000 population for males of all races in the 15–19 year age group. In general, the problem is greater among white males than non-whites, although in some minority groups the incidence of suicide is considerably higher than in the general population. A striking example is found among American Indians and Alaskan natives where the suicide rate in the 15–24 year age group is approximately 45 to 100,000 population, compared with 11 per 100,000 among all other persons in the U.S. in that age range. However, suicide is the second leading cause of death among all males between the ages of 15–19 years insured with the Metropolitan Life Insurance Company. Despite the fact that the age of reason is often thought to begin around the age of 10 years, suicide is listed as the eighth leading cause of death among young males 5–14 years of age in the 1974 edition of *Facts of Life and Death*, published by the National Center for Health Statistics in the Health Resources Administration, U.S. Department of Health, Education, and Welfare.

SEX DIFFERENCES

Historically, males have been regarded as committers of suicide, while females have been viewed as attempters. The facts continue to bear out this belief, as a general rule. Nevertheless, both sexes can and do attempt the act for a variety of reasons, such

as impulsivity, feelings of personal rejection, hurt and anger, the desire to get back at someone else by making him sorry, misguided martyrdom, loss of face, fear of disgrace, and the like. One 12-year-old was found in the bathroom beside a torn report card with a series of failing grades on it. Still another teenager got himself arrested and committed suicide in the same jail cell where an older brother had done so a year earlier to the day. "Anniversary" suicides are not at all uncommon.

A typical profile for the young suicidal male is one in which the father has died or been separated before the boy is 16 years of age. The father is often a successful professional or business man. There has been a characteristic lack of close father-son relationship which brings on feelings of rejection, anxiety, sleeplessness, and heavy smoking.

By contrast, the young suicidal female is the product of a self-centered mother and an ineffectual father. After feeling rejection by her family and or boyfriend, she frequently attempts to take her life. Thus, fathers are particularly important figures with both sexes. In the past, the mother has been regarded as the prime parent of the child and has unfortunately received the bulk of the blame for childhood misbehavior and the subsequent emotional and mental problems. Many serious emotional problems, especially those with boys, can be laid squarely at the doorstep of the father. If the father takes an active part in the child rearing process, young boys especially are likely to reap the benefits in a most constructive way.

TYPES OF SELF-DESTRUCTIVE BEHAVIOR

Three terms are frequently used to characterize acts of a self-destructive nature. *Self-assaultive behavior* suggests an attack or assault upon the self. Such an act may not be clearly suicidal. It is not uncommon for children to threaten injury to themselves or others. They may verbalize the fact by warning a parent or parental surrogate that they intend to hurt themselves. Persons experiencing repeated injuries are called "accident prone." These acts are often aimed at gaining love and sympathy which are not felt through other avenues. This may stem from sibling rivalry in an effort to draw attention away from the rival at almost any cost.

The term *self-destructive behavior* ordinarily connotes more serious cases than those in the self-assaultive range. There are varying degrees of intensity, and clearly self-destructive acts blend unmistakably with overt suicide. "Psychological equivalents" of suicide or self-destruction may be difficult to recognize because they can rest beneath the level of consciousness. As an illustration, we might cite the youngster who has a physical infirmity such as diabetes and fails to take insulin properly, even after having been carefully instructed about the importance of the procedure. Different degrees of understanding may exist regarding death, even among older teenagers. Some youngsters live in a virtual dream world and feel as though they will be saved at the last moment and nothing will happen to them no matter what they do. On the other hand, they may feel the risk is worth taking just one time, especially if there is a need to meet with some peer-group approval.

There is doubt about the exact age at which a youngster really understands the concept of death, particularly suicidal death. In the author's experience, the youngest age at which suicide appeared to be clearly understood appeared in a very bright five year old boy. Following a thorough examination of both child and parent, it became clear he engaged in overt suicidal attempts which were rooted in conflict with his parents. Most youngsters seldom appreciate suicidal death before the age of seven or eight years. Some authors believe suicide is not fully understood before the age of 9 or 10. The age at which youngsters can comprehend the nature of their actions regarding death will vary with cultural background, relationship to parents, presence of older siblings, intelligence, and exposure to violence, both within and outside of the home setting.

Suicidal behavior, per se, can be viewed as less equivocal than the other two categories. It may be defined as any willful act designed to bring about one's own death. A person may injure or destroy a part of himself without actually taking his own life, of course. This is the reason why self-assaultive or self-destructive behavior are useful dimensions on the continuum of behavior. A finality exists in suicide which sets it apart, at least in principle, from the others, even though the difference may be a matter of degree.

"GATEKEEPER" ROLES

A number of persons who come in contact regularly with youngsters may provide first-line intervention, both in terms of spotting the difficulty during its incipiency and in rendering initial "psychological first-aid." Such persons may be club leaders, teachers, high school counselors, scout leaders, church

group leaders, and the like. Youngsters who are in difficulty emotionally are often likely to talk to another adult, rather than to their own parents. It is important for a youngster to have a leader or counselor who can establish the image of a stable and trustworthy friend. Because of the lack of such a relationship with adults, youngsters often turn to peers for support, many of whom are not capable of providing it or may be harmful influences in and of themselves.

IDENTIFICATION OF POTENTIAL SUICIDES

Numerous contributing factors are apparent in self-destructive behavior, but the experience of personal losses continues to be a pervasive theme. These losses include those which are internal, such as loss of self-esteem, loss of confidence, or loss of face, resulting in humiliation. Then, there are external losses which are especially traumatic, such as loss of a job, loss of standing in school, or loss of a loved friend or relative. Many precipitating events which seem miniscule and insignificant to adults are viewed as monstrous to a young person.

Behavioral clues that may aid in suicidal identification may be either overt or covert. Overt behavioral clues include actions such as purchasing a rope, guns, or pills. Covert behavioral clues are shown by loss of appetite, loss of weight, insomnia, disturbed sleep patterns, fatigue or loss of energy, isolated behavior, changes in mood, and increased irritability. Signs of deterioration are often revealed by a sudden change of behavior, which may not be flagrantly rebellious enough to include rule breaking and legal violations.

Symptoms of depression are not always strikingly apparent, especially among youth. When these signs often do appear, the youngster may not have all the classical signs, such as loss of appetite and weight. It is a mistake to feel that an individual will not take his life unless he is clinically depressed. Adult depression and youthful depression may not be synonymous. Behavior patterns to look for in potentially self-destructive youth include the following:

- Adolescents contemplating suicide are apt to have little solid verbal communication with their parents. In fact, this is part of the problem. They are more likely to communicate with a peer or another interested individual in whom they have some faith and trust. Thus, if it is apparent that a youth cannot talk to his parents, the listener should be alert to the nuances of a serious problem.
- A prized possession may be given away with the comment that it will not be needed any longer.
- The individual is apt to be more morose and isolated than usual.
- Young males are likely to have experienced the loss of a father or a close male figure through death or divorce before the age of 16 years.
- Girls who attempt suicide are likely to show much difficulty with their mothers, especially in the presence of an inadequate father figure.
- Adolescents are apt to smoke heavily, suggesting the presence of severe tension or anxiety.

- General efficiency and school work performance may decline markedly.
- Drug and alcohol use have increased in recent times, accompanied by anxiety, depression, and irritability.
- Even though apparently "accidental," one should be alert to instances of prior self-poisoning behavior, if known. The same youngster who tries to kill himself frequently has a history of self-poisoning, often requiring medical treatment. Ultimately, this behavior will result in self-destruction.
- Homes in which the professional suspects child-abuse, or finds the so-called "battered child" syndrome, are cause for serious concern, since there is mounting clinical evidence to indicate that future violence, including suicide, may evolve from abuse in childhood. If the youngster feels openly rejected by his parents, this feeling should be noted, even if severe physical punishment is absent.
- It may be helpful to look for verbal or behavioral signs which suggest a desire to get even with parents. A prominent component in suicidal behavior is the wish to make those left behind sorry that they did not treat the victim better when he was alive.

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

PSYCHOLOGICAL FIRST-AID

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

Step 1: Listen

The first thing a person in a mental crisis needs is someone who will listen and really hear what he is saying. Every effort should be made to understand the feelings behind the words.

Step 2: Evaluate the seriousness of the youngster's thoughts and feelings.

If the person has made clear self-destructive plans, however, the problem is apt to be more acute than when his thinking is less definite.

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

It is possible that the youngster may be extremely upset but not suicidal. If a person has been depressed and then becomes agitated and moves about restlessly, it is usually cause for alarm.

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

Do not dismiss or undervalue what the person is saying. In some instances, the person may express his difficulty in a low key, but beneath his seeming calm may be profoundly distressed feelings. *All* suicidal talk should be taken seriously.

Step 5: Do not be afraid to ask directly if the individual has entertained thoughts of suicide.

Suicide may be suggested but not openly mentioned in the crisis period. Experience shows that harm is rarely done by inquiring directly into such thoughts at an appropriate time. As a matter of fact, the individual frequently welcomes the query and is glad to have the opportunity to open up and bring it out.

Step 6: Do not be misled by the youngster's comments that he is past his emotional crisis.

Often the youth will feel initial relief after talking of suicide, but the same thinking will recur later. Follow-up is crucial to insure a good treatment effort.

Step 7: Be affirmative but supportive. Strong, stable guideposts are essential in the life of a distressed individual. Provide emotional strength by giving the impression that you know what you are doing, and that everything possible will be done to prevent the young person from taking his life.

Step 8: Evaluate the resources available.

The individual may have both inner psychological resources, including various mechanisms for rationalization and intellectualization which can be strengthened and supported, and outer re-

sources in the environment, such as ministers, relatives, and friends whom one can contact. If these are absent, the problem is much more serious. Continuing observation and support are vital.

Step 9: **Act specifically.**

Do something tangible; that is, give the youngster something definite to hang onto, such as arranging to see him later or subsequently contacting another person. Nothing is more frustrating to the person than to feel as though he has received nothing from the meeting.

Step 10: **Do not avoid asking for assistance and consultation.**

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

Additional preventive techniques for dealing with persons in a suicide crisis may require the following:

- Arrange for a receptive individual to stay with the youth during the acute crisis.
- Do not treat the youngster with horror or deny his thinking.
- Make the environment as safe and provocation-free as possible.
- Never challenge the individual in an attempt to shock him out of his ideas.

- Do not try to win arguments about suicide. They cannot be won.
- Offer and supply emotional support for life.
- Give reassurance that depressed feelings are temporary and will pass.
- Mention that if the choice is to die, the decision can never be reversed.
- Point out that, while life exists, there is always a chance for help and resolution of the problems, but that death is final.
- Focus upon survivors by reminding the youngster about the rights of others. He will leave a stigma on his siblings and other family members. He will predispose his friends and family to emotional problems or suicide.
- Call in family and friends to help establish a lifeline.
- Allow the youngster to ventilate his feelings.
- Do not leave the individual isolated or unobserved for any appreciable time if he is acutely distressed.

These procedures can help restore feelings of personal worth and dignity, which are equally as important to the young person as to the adult. In so doing, the adult helping agent can make the difference between life and death. A future potentially productive young citizen will survive. □