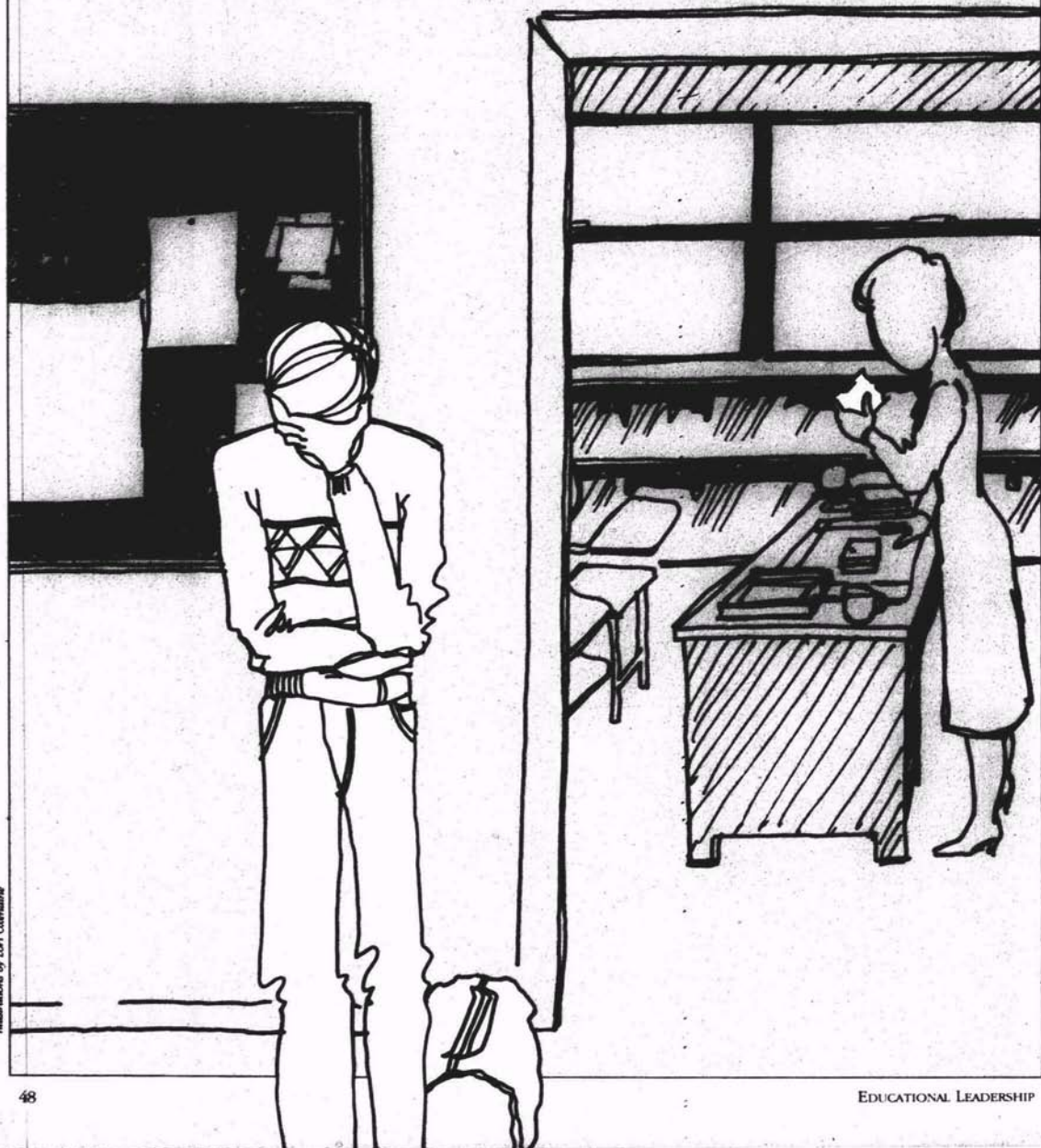


Early Prevention of Adolescent Suicide



Illustrations by Lori Chernobin

Intervention assistance teams in schools can prevent teenage suicide by identifying signs of emotional distress and destructive behaviors long before adolescence.

It is against the natural order of life to bury our children. As parents and educators, we can, in time, reconcile ourselves to the loss of a child through accident or illness. But the choice of a child to end his or her own life is a different matter. We who are dedicated to nurturing human potential are appalled. Suddenly, part of the future is gone forever.

Tomorrow in the United States approximately 1,000 adolescents will attempt suicide. Eighteen will succeed. During the same period, twice as many young adults between the ages of 20 and 24 will end their lives.

Six Young Men

For one tiny school district in rural Ohio, these statistics have become a recurring nightmare. In slightly over three years, six young men (see box) committed suicide. All were students or former students at the local school.

Theirs was an American boyhood in the Mark Twain tradition. As youngsters, they fished in farm ponds and paddled inner tubes along the banks of a quiet river. Like Tom Sawyer, they were boys, not saints. Unlike Tom, they did not live to hear their own eulogies. Each chose for himself a sure and violent death before the age of 24. The compelling question is "Why?"

In an attempt to determine where the boys' problems began, we analyzed their school records, with particular attention to grades, behavioral reports, and anecdotal notes of teachers. We also interviewed their friends, families, and teachers.

The findings revealed commonalities. In each case, signs of trouble had surfaced long before the final event. While each suicide *appeared* to be situation-specific, a psychological storm had been gathering for years, caused by emotional vulnerability, family dynamics, and social forces—the decision to commit suicide develops over time.

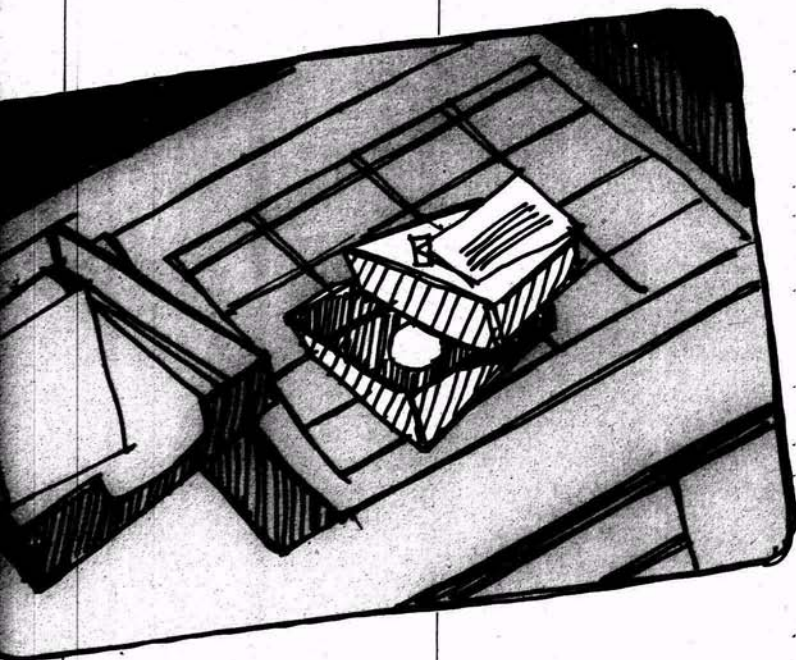
Patterns of Failure

Educators have tried to stem the tide of teenage suicide by recognizing the symptoms—some 28 at last count—which seem to precede the event. There are two fallacies in this ap-

proach. First, many of the so-called symptoms of suicide—boredom, change in eating and sleeping habits, rebellious behavior—are typical of teenagers. Furthermore, when the most blatant symptoms appear, such as giving away one's prized possessions or verbalizing feelings of hopelessness, it is often too late. Among young suicide victims, two-thirds have undergone psychological counseling, and one-third have been hospitalized (Griffin and Felsenthal 1983, pp. 27–28). Clearly, problems must be diagnosed and treated earlier if we are to intervene successfully.

In his recent work, *Definition of Suicide*, Schneidman (1985) describes deep consistencies in lifelong coping patterns. Accordingly, "habitually dysfunctional patterns of reacting to threat, pain, stress, and failure make dire predictions of a tragic suicidal outcome." Schneidman concludes that suicide, although enormously complicated, can often be predicted. It is this predictability that gives us hope for prevention.

The youngsters Schneidman describes as the "walking wounded" surface early in the educational process. Eli Bower (1960) characterizes them as "those children who are unable or will be unable to take the slings and arrows of life without caving in, becoming immobilized, or exploding." Their vulnerability creates a pattern of seeking escape from painful situations. The "flight" pattern emerges early in life. Rejected by their peer group, they isolate themselves from all but other alienated youth. Unhappiness in school usually creates a history of high absence and truancy; as adolescents they often get into trouble with the law. They accurately view themselves as outcasts at school, disappointments to their families, and pariahs in the community. They run away. One-third of all runaways are acutely suicidal (Wenz 1985). All of these behaviors constrict remaining options. Eventually, they arrive at a half-conscious decision to act decisively should yet another crisis occur. One escape remains. Only by taking his or her life can such a youngster finally control the future. This is the ultimate paradox.



"It is the early childhood teacher who can first identify the child with dysfunctional coping behaviors."

Early Signs of Vulnerability

The word "unhappy" was used early and often in teachers' descriptions of the six young men. Most of them did not do well in school. Several were identified as learning disabled. Failure in school is widely noted by peers and adults and diminishes a youngster's self-esteem.

Anxiety disorders such as loneliness, shyness, withdrawal, tenseness, and extreme perfectionism are also frequent descriptors of children who ultimately take their own lives. Along with these destructive traits go impulsivity, hyperactivity, and restlessness. This fact was underscored in the boys' histories. Young people with poor impulse control may make a fatal suicide attempt without intending a fatal outcome. Studies of the fingerprints on the trigger of the death weapon frequently show that even the most apparently determined victims often change their minds in the instant after the fatal decision (Giacometti 1986).

The family is sometimes the perpetrator and always the co-victim of the event. While 50 percent of all young suicide victims come from bro-

ken homes, it is not unusual for intact families to experience the suicide of a child. Even when the family remains intact, its nurturing role disintegrates when life at home is hectic and there is little time to communicate. Also, the death by suicide of a parent greatly increases the possibility of suicide in the offspring. In fact, children who experience the suicide of a close family member are nine times more apt to take their own lives than other youngsters (Griffin and Felsenthal 1983, p. 170)

By the time they reach high school, these troubled young people often become substance abusers. Rebellion is part of adolescence and the peer group regards experimental use of drugs and alcohol as recreational. Normal kids pass through this crazy stage, but vulnerable youth get stuck. Of youth who are chemically addicted before graduation from high school, many will be dead before the age of 30 (Johnson 1987). But substance abuse is not the cause of suicide; rather, it is an effort to medicate feelings of inadequacy, to reduce inner tension, and to restore equilibrium to a dysfunctional emotional system.

The School's Role in Prevention

By all accounts, it is the early childhood teacher who can first identify the child with dysfunctional coping behaviors. This finding is widely verified in the research on identification of emotionally handicapped children and was evident in the anecdotal notes written into the early school records of the boys we studied. Acting out behaviors are symptomatic of extreme turmoil within the mind of the young person (Griffin and Felsenthal 1983). For example, the child may set fires, talk back to teachers, fight with peers, skip classes, or be truant.

It follows, then, that in their daily interaction with children, teachers have the greatest opportunity not only to identify maladaptive behaviors but to break the patterns of destruction.

Six Young Men

David was an honor student, star quarterback on his high school football team, and a perfectionist who "gave 100 percent" to everything he did. When he earned an athletic scholarship to a prestigious Midwest college, the community shared his family's pride. But by the beginning of his sophomore year, things were not going well. After he was cut from the college football team, friends began to notice his despondency and strange behavior. They urged him to sign himself into the hospital. Hours later, David slipped out of the psychiatric ward and made his last run. Dashing down the corridor, he plunged through a plate glass window to his death three floors below.

Eddie's elementary teachers described him as "immature," "impulsive," and "capable of doing more." Despite the help he received in the learning disabilities program, Eddie never managed to graduate from high school. Late in his senior year, he got into trouble with the law. Unable to wait for the outcome of an indictment hearing, he hung himself from the back of his truck. Meanwhile, his attorney was trying to contact him to give him the good news that his case had been dismissed.

Paul, a sensitive, artistic 17-year-old, lived with his stepmother and his father, a successful advertising executive. His natural mother had been hospitalized on several occasions for emotional problems. During high school, Paul drifted into the "punk" crowd and spent much of his time absorbed in "heavy metal" rock. One night he was cited for driving under the influence. Instead of going to school the next day, he shot himself.

Fifteen-year-old Eric was a loner in his 8th grade class. As a youngster, he had been diagnosed as "hyperactive" and took Ritalin to control his disruptive behavior in class. Teachers described him as unhappy in school. Later, they would note that he always tried very hard to please. In junior high school Eric was a tense, anxious youngster who was obsessed with militarism and teased by his schoolmates. He spent much of his time playing "Dungeons and Dragons." One summer afternoon he hung himself. There was no apparent reason.

Joe had a history of poor school attendance. His measured intelligence ranged from 103 to 85. He suffered from migraine headaches and got into minor disciplinary scrapes. A notation on his school records simply said "difficult home situation." Joe failed 7th grade but was placed in 8th grade; subsequently, he failed 8th grade and was placed in 9th grade. He failed 9th grade, and the following year, now a 17-year-old freshman, he did not return to school. In the years that followed he began to drink heavily and was unable to hold a job. After his girlfriend ended their relationship, Joe was convicted on the last of several DWIs (driving while intoxicated). He ended his life.

"Dearest Family," wrote Fred in his last note. "I just couldn't seem to get it together; then booze and pot got hold of me. I just want you to know that I love you more than I could ever say. . . ." Fred was the youngest in a family that placed great value on education. Both his brother and sister already had master's degrees. But from the first day of kindergarten, Fred had hated school. He had difficulty concentrating and could not cope with frustration. After high school graduation, he made three attempts at attending college. Dropping out for the last time, he was unable to find steady work in a depressed Midwest economy. When he was turned down by the military because of a prediabetic condition, he became severely depressed. Shortly after, he was picked up on his second DWI charge. Facing a long jail term, he chose to end his life.

A Team Approach to Intervention

The most promising innovation in schools today is the team approach to addressing the needs of individual youngsters. The idea originated with chemical intervention teams and special education placement teams. More recently, creative educators are broadening the scope of the school-based team to include all children who need extra help to function effectively. Based on the concept of combined expertise and a vigorous proactive approach, the team is committed to early intervention and remediation.

The intervention assistance team concept calls for each building within a school district to have a faculty team consisting of the principal, some classroom teachers, and special services personnel such as the school's psychologist, counselor, nurse, and social worker. This group meets on a regular basis. The classroom teacher who refers a child becomes an essential member of the team with regard to that particular youngster.

The intervention assistance team serves a number of valuable functions. Because of its members' sensitivity and knowledge of local resources, it

determines whether further remedial steps should be taken. The team may recommend various types of group or individual counseling within or outside the school, or they may recommend curriculum-based strategies that focus on self-awareness, communication, decision making, problem solving, personal alternatives, and resources.

Whether the primary intervention plan is with the school or with a community agency, the team participates in implementing treatment, monitoring results, revising strategies, and providing long-term follow-up. Vulnerable children are guided through their difficulties with the collective hand of concerned adults on their shoulders. □

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