

# Managing suicidal adolescents

## Suicidal adolescents have a different set of problems than suicidal adults.

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The management of suicidal behaviour tends to evoke a range of feelings and responses in health practitioners. These include anxiety, confusion, hostility, avoidance and a host of other negative feelings, many of which may be due to uncertainty and perceived impotence in dealing with the patient's self-destructive ideas and behaviours.

Adolescents with suicidal tendencies have a rather distinct set of problems compared with those affecting adults. The management of the suicidal ideation may rest on the resolution of those difficulties and the alleviation of depressive symptoms.

As suicidal ideation and behaviour are linked to the presence of depression it is important that clinicians first assess (i) depressive manifestations; and (ii) suicide risk.

### Assessing depressive symptoms

The guidelines and criteria set out in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision) (*DSM IV*)<sup>1</sup> represent a fairly standardised approach. For the exact criteria and time frames you are encouraged to consult the *DSM IV*. Box 1 lists the major symptoms that characterise depressive disorders.

### Assessing suicide risk

The various areas of enquiry necessary for establishing the extent to which the adolescent's presentation constitutes ongoing suicide risk are listed in Box 2. The level of hopelessness is a critical indicator of suicide intent.<sup>2</sup> Hopelessness refers to pessimism or negative thinking about the future. Individuals who are unable to see a positive outcome to their situation are considered to be at higher risk than those who believe that their problems can be resolved. Young people who appear to have little or no social

#### Box 1. Symptoms of depression

- Depressed mood
- Reduced interest in usual activities
- Significant weight change
- Sleep disturbance
- Appetite disturbance
- Loss of energy or fatigue
- Psychomotor retardation or agitation
- Reduced concentration
- Feelings of worthlessness or inappropriate guilt
- Suicidal ideation

support also constitute higher suicide risks than those who have friends and family to whom they can talk. Individuals who appear to have developed a plan regarding the method of suicide must be taken very seriously, as this suggests a rather advanced stage of suicide ideation. Threats made, directly or indirectly, should not be ignored, as they are an indication that the young person has thought about suicide as a way of dealing with the particular stressor. Similarly those with access to lethal means, especially firearms, also pose a considerable risk in view of the evidence. The level of impulsivity in some young people must also be taken into account, since some forms of suicidal behaviour, mainly non-fatal suicidal behaviours, may represent impulsive reactions.

Losses of significant others (through death or termination of relationships) pose a more pervasive risk, and can result in the individual questioning their reason for living, in the absence of the significant other.

## Adolescents with suicidal tendencies have a rather distinct set of problems from those affecting adults.

### Box 2. Suicide risk factors

Depression  
 Level of hopelessness  
 Social support  
 Plan  
 Chronic stress & poor coping ability  
 History of suicidal behaviour  
 Substance abuse  
 Direct or indirect threats  
 Significant losses  
 Impulsivity  
 Access to firearms and other lethal means

### *Intervening in suicidal behaviour (crisis stage)*

Intervention strategies in suicidal behaviour comprise two broad areas. The first involves crisis intervention, and thereafter referral for psychotherapy by a clinical psychologist or psychiatrist.

Crisis intervention refers to the immediate management of the emotion and intense distress that the young person is experiencing. The priorities include supporting, containing and ensuring that he/she knows there is someone who cares. During this stage the goal is usually not the resolution of the underlying problems. The following general principles are important:

- listen
- be actively engaged, but not passive
- encourage the person to talk
- be supportive and empathic
- speak calmly to help reduce agitation
- avoid being judgemental
- help the person to realise he/she is not alone
- help him/her to realise there are alternatives
- offer to assist or mediate where possible
- focus on reducing the level of hopelessness
- focus on the precipitating event
- remove lethal means
- short-term hospitalisation if ongoing suicide risk appears high.

In addition, the points in Box 3 are worth remembering as clinicians can often become anxious and panicky when faced with suicidal patients. This feeling can result in a sense of

desperation to do everything possible to help. Even though well intended, some of these responses may be ineffective or even counterproductive. At the other extreme, there are clinicians who respond rather callously or impatiently to those who present after suicidal behaviours, viewing them as a nuisance to health care services. While clinicians' caseloads, especially in general hospitals, are very high, they need to ensure that every patient receives the same degree of care and empathy. It must be noted that patients who engage in suicidal behaviour do not do so to give you more work, or because 'they're just being silly' or 'manipulative'. Suicidal acts, whether fatal or non-fatal, are indications of the severe levels of psychosocial distress being experienced. It is important to note that the lethality of the suicidal behaviour is not always a good indicator of the adolescent's level of psychosocial distress. We have seen adolescents from extremely pathological circumstances make relatively harmless suicidal gestures: they nevertheless warrant full psychosocial care and follow-up. Non-fatal suicidal behaviours in adolescents should rather be understood as expressions of the powerlessness and hopelessness they feel in the face of conflict situations. These account for their resultant turn to suicidal behaviour as (i) a temporary escape from the prevailing stress; and (ii) a way of communicating their distress.<sup>3</sup>

### Box 3. Some 'don'ts' to remember

- Don't be too quick to give advice and come across as a 'know it all' – focus instead on problem solving
- Don't give superficial reassurance – it tends to reject the pain the individual is feeling
- Don't hide the fact that you're human too. Admit that you have difficulty coping at times
- Don't come across as too professional and 'together' – it detaches you and makes the individual feel more inadequate and worthless
- Don't leave the individual alone – ensure that there are people around

### *Management after the crisis stage*

Resolution of the crisis is a necessary but insufficient intervention in adolescent suicidality. Although not a discretely separate stage, intervention after the

crisis resolution stage must attempt to resolve the underlying issues that may have precipitated the distress. At this stage the adolescent should be less agitated, and relatively more amenable to rational exploration of the issues that are the source of distress. Considering that most adolescent suicidal ideation and behaviour are related to interpersonal conflicts (often with parents), it is crucial that intervention involves the family as well. Initially this means consulting with the adolescent individually and conducting separate family consultations.

## Individuals who appear to have developed a plan regarding the method of suicide must be taken very seriously, as this suggests a rather advanced stage of suicide ideation.

Individual sessions with the adolescent typically focus on helping her/him explore the conflictual issues in a non-judgemental context, during which the clinician listens and helps the young person think about and consider alternatives. It is helpful for the clinician to encourage the adolescent to translate complaints into problems, because problems can be solved, while complaints are merely negative attitudes and views. The problem-solving approach can encompass simple, practical ways of intervening in some conflicts faced by adolescents. This involves helping the patient articulate the problem clearly, and then list all possible resolution strategies, regardless of how effective they may be. Then encourage the adolescent to consider each solution (one at a time) by examining its pros and cons. In this way the patient arrives at a final list that clearly illustrates her/his best option. It is important that this, or any other problem-solving technique, should not be done for the patient, but rather that the clinician facilitates the process for the young person to perform. This is a more empowering approach in the long term, as it teaches problem solving rather than simply solving the immediate problem.

Family-based interventions should be sensitive to the complicated feelings of the

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parents/caregivers, and should allow them to voice their views of the problems in a non-judgemental context.<sup>4</sup> Initially parents/caregivers should be seen alone. It is important that the clinician remain neutral and does not align overtly with any of the parties involved. The clinician should convey an attitude of deep concern, emphasise that the adolescent has engaged in life-threatening behaviour and that solutions need to be found that minimise ongoing risk. Parents and caregivers may express fear, guilt, exasperation, helplessness or hostility towards the adolescent. These feelings need to be accepted by the clinician who should allow these feelings to be framed as reasonable but ineffective perspectives on the presenting problems.

Successful parent interviews usually present the clinician with a series of practical interventions that the family as a unit might attempt. The clinician can then act as the facilitator to these interventions. Subsequent meetings can include the adolescent and a problem-solving approach should be pursued. Such efforts should allow the family system to propose mutual changes to recognise and deal with the problems leading up to the suicidal behaviour. The clinician must respect all parties but will have to risk selective alliances with certain individuals on specific issues as particular concerns and suggestions are raised. Care should be taken not to destabilise family hierarchies, unless these are frankly abusive or pathological. Follow-up sessions should monitor changes made, explore resistance, encourage constructive communication by all parties and create an atmosphere of openness and joint problem solving. Resistant families where unproductive conflict and ongoing suicide risk persist should be referred for specialist interventions or consultation where these are available.

### No-suicide contracts

Such 'contracts' are really an agreement made between the patient and clinician, in which the patient 'contracts' not to engage in a self-harm behaviour in the time between the current consultation and the next, and that she/he contacts the clinician if feeling suicidal. These 'contracts' are only effective if there is a strong alliance between the clinician and the patient, and are not a substitute for building and maintaining therapeutic rapport. The contract can be renewed from session to session depending on the need. While the agreement can be in

writing, it does not have to be so. While this is not a legally binding contract it reinforces the connectedness between the patient and her/his health care provider.

While the empirical evidence for using a no-suicide contract is varied, there are clearly obvious benefits for the suicidal person. Among these are: (i) the knowledge that someone cares; (ii) the feeling of empowerment that comes with knowledge of available resources; and (iii) the commitment generated by the 'contract'.

### Providing resource contact details

Research has demonstrated the effectiveness of providing suicidal and post-non-fatal suicidal behaviour patients with contact details for supportive resources and crisis centres. A standard practice should therefore be to ensure that patients who are or have been suicidal leave the consultation with a list of telephone numbers or addresses of help agencies they can contact should they feel the need. These include the contact details for agencies like Lifeline and other crisis centres within the adolescent's district. It is particularly helpful to provide these details on a piece of paper that the young person can keep and use should the need arise. The Green Card Study in the UK confirmed that this piece of paper brings much comfort and security to suicidal people, who more often than not do not access the stipulated resources, but report feeling supported and confident simply knowing these resources are within reach.<sup>5</sup>

### Hospitalising

As with all clinical care, there are specific indications for hospitalising suicidal adolescents, and it is important to avoid the tendency to admit every young suicidal person. The guiding factors in this decision revolve around the suicide risk factors mentioned above. High levels of hopelessness coupled with insufficient family support would motivate a decision to hospitalise. Where reasonable environmental support and monitoring are forthcoming, suicidal adolescents can be managed on an outpatient basis. In cases of adolescents with high levels of hopelessness and inadequate support from significant others, admission and close suicide watch need to be activated. This would also entail consulting a mental health specialist.

## Conclusion

While suicidal adolescents pose significant challenges in management, approaching intervention in a systematic manner and including the family in the process can be very helpful. It is also crucial that health workers respond to affected adolescents with the empathy and concern they deserve.

### References

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## In a nutshell

- Suicidal adolescents can evoke anxiety and even hostility in clinicians, and a calm approach will benefit the clinician, the patient and her/his family.
- Depressive symptoms must be assessed early on as this helps to establish the course of the problem and its management.
- Assessing suicide risk is a significant component of the initial consultation.
- Levels of hopelessness and availability of support from significant others are among the useful indicators of suicide risk.
- The first stage of dealing with a suicidal adolescent is crisis intervention, which involves supporting, containing and ensuring she/he knows that someone cares.
- Once the crisis dissipates, intervention must be aimed at the underlying issues, which are often interpersonal conflicts.
- Individual consultations with the adolescent must focus on helping her/him learn problem-solving skills.
- Family sessions are also important, since they have a role to play in helping the young person.