Youth at risk

How to help the suicidal teen

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Suicidal adolescents consult their medical practitioner for psychological distress usually by expressing physical complaints. The general practitioner must have the ability to detect, evaluate, or treat the problem, or to refer patients to other resources. This article helps the practitioner to recognize the teenager at risk of suicide, to systematically evaluate that risk, to understand the role of mental illness in this problem, and to proceed with treatment or referral.

In Canada, Quebec is the province with the highest level of youth suicide. In 1996, the prevalence was 2.6/10,000 in the 10 to 14 age group, and 20.7/10000 in the 15 to 19 age group.

From 1950 to 1980, the suicide rate increased four times for youths aged 15 to 19, and twice for the younger age group (10 to 14 years).

The major means to achieve suicide for girls and boys is by hanging. The second choice for boys is the use of firearms, while for girls it is medication overdose.

In this article:

1. How to detect a suicidal teen.
2. What are the precipitating factors of teen suicide?
3. How to evaluate suicidal intention.
4. What are effective treatment options?

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What can the GP do?

Suicidal individuals are often ambivalent about seeking help, and frequently consult their doctor for somatic problems. They have more visits than their non-suicidal counterparts, but only

2% come for psychological distress. This group, however, has more psychiatric diagnoses. Before attempting a suicide, 32% to 38% of suicidal individuals consult their doctor. In Quebec, in 1995, 79% of teenagers consulted their medical practitioner in the year preceeding the suicide, and 24%, the month before.

As such, the medical practitioner plays an essential role in the detection of patients at suicidal risk. Continuity of care is the best method of detecting a suicidal teen.

After detecting a risk factor for suicide, perform a medical and psychiatric evaluation: evaluate the psychological distress of the patient, the suicidal risk, and his/her general functioning. Proceed with treatment of the psychiatric disorders, and direct the patient to community resources.

Katie's case

The situation

Katie, 15, is having suicidal thoughts, and feels out of control. She wanted to hang herself but finally, talked about it with her mother. Her worried parents tell you she has not been the same for two months. She has become very irritable, and is constantly fighting with them. During the last month, she has vaguely mentioned feeling like a burden to people, and that her parents would be better off without her.

Katie's parents inform you that during these past two months, she has become more and more isolated in her room or is going out with new friends, and always feels criticized by her parents. Her parents are happy that she now has some friends, yet they do not approve of them. They are quite worried about their influence (drugs, behaviour problems, *etc.*). Katie refuses to go to school and complains of multiple problems, such as stomach ache, nausea, and dizziness.

Katie's history

Before this period, Katie was a shy girl who worked very hard at school to achieve an average of 70%. She has now lost motivation, stopped studying, and her marks have consecutively dropped dramatically. Katie refuses to talk. Finally, her parents tell you about the financial problems at home. In response to this stress, the parents are more tense and are fighting frequently. During the meeting, the mother is crying and feels quite guilty.

Turn to page 98 for more on Katie.

What are the characteristics of suicidality?

Suicidal youth most often consult with a medical practitioner just before or after attempting suicide. It is important to not only evaluate the suicidal intention, but also all of its characteristics. The following four aspects should be examined.

1. Suicidal intent and lethality

Suicidal intent is the intensity with which the suicide attempter wishes to die, *i.e.,* the frequency of suicidal thoughts, and the circumstances in which they appear (Are they recurrent or do they only appear following frustration or a fight?). Suicidal intent includes the severity of these thoughts from passive thoughts to thoughts accompanied by a wish to die, and most seriously, to suicidal thoughts with an active plan. The planning of the suicide must be evaluated (preparation, writing a will, saving pills, giving away belongings, *etc.*), as well as the planning of the attempt where rescue arrives (prevention of discovery).

The following points must also be investigated:

- Has the teenager communicated to someone his/her wish to die?

- Does he/she have the capability to attempt/complete the act?
- Does he/she have the opportunity to talk to someone?

Recurrent suicidal thoughts, with a desire and a plan to die, increase the probability that the suicidal attempt will occur.

The higher the lethality of the attempt or the intention, the higher the risk of the suicide's completion. Such methods include shooting, jumping, hanging, or carbon monoxide poisoning. Younger children engage in poorly organized suicidal behaviour of very low lethality, but the intent to die can be quite high. A teenager with high impulsiveness and a low intention to die may, however, perform a dangerous act. We should, of course, look at the availability of lethal agents. Make sure the parents remove any firearms from the house, not just lock them away. Teenagers usually know where to find the keys.

Previous suicidal attempts must be questioned. Young people who have engaged in past attempts are three times more likely to attempt suicide again.

Practice Pointers

When evaluating suicidal intention examine:

- suicidal intent and lethality
- past and current psychopathology
- psychological characteristics and meaning of the precipitating factors
- family and environmental factors

2. Past & current psychopathology

Ninety per cent of the teenagers who have attempted suicide have evidence of psychopathology. The most frequent conditions are depressive disorders,[1,2] bipolar disorder,[3] conduct disorder,[4] others,[5] anxiety disorder,[6] and substance abuse disorder. They are often seen in multiple combinations which increase the suicidal risk. These combinations also increase the resistance to treatment. Thus, the number of comorbidities increases the suicidal risk, and the recurrence of these depressive conditions.

3. Psychological characteristics

A typical portrait of a suicidal teenager can be someone with low self-esteem, lack of assertive-

Table 1
Essential treatment steps

1. Establish a no-suicide contract
2. Secure compliance to treatment
3. Treat psychosocial factors and psychopathology
4. Determine the level and intensity of care

ness, lack of ability to resolve conflicts and problems, poor control of emotions with a lack of social skills. They also exhibit a behavioural desinhibition, and a background of hostility and aggressiveness.

Teenagers with cognitive distortions, such as not feeling in control of their own life or others, or feeling that everything always goes wrong, can easily feel overwhelmed following an interpersonal crisis or loss. With a bit of impulsiveness, these teens may engage in suicidal attempts.

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The hopelessness is often correlated with depression and is connected to suicidal intent. The restoration of hope is the first step in treatment. This helps the teen to engage in treatment and reduces the likelihood of suicide.

Developmental tasks predispose teenagers to overreact to crises when they have some underdeveloped skills. These teenagers are more insecure with the responsibilities of growing up, and cannot achieve the separation-individuation task.

Along the same lines, factors which affect sexual identity development increase suicidal risk, such as past and current sexual abuse. Being homosexual is also a risk factor.

Harassment in school or in any social setting increases the hopelessness of the teenager, and should be examined closely. In addition, when a well-known personality commits suicide, a teenager with poor identity formation, may commit suicide by imitation.

4. Family & environmental factors

Family discord or disciplinary crises, as well as interpersonal conflicts or loss, are the most frequent precipitants of suicide attempt. The break-up of a relationship for these teenagers often feels like the end of the world.

Often, there are stressful events in the family (divorce, the eldest leaves the home, unemployment, financial problems, sickness, or loss). The parents of suicidal attempters have more psychiatric illnesses (depression, substance abuse, aggressive behaviour, personality disorder) and have committed more suicidal attempts themselves. It may be a genetic and an environmental factor. Neglect and lack of parental supervision are predisposing and precipitating factors in suicidal intent and attempt.

Finally, academic difficulties, low grades, suspension, fights with teachers, learning disabilities and undiagnosed attention deficit disorder are other factors to consider in evaluation and treatment. These situations need to be addressed and the practitioner should provide help and support.

How do I approach treatment?

There are four major steps which must be considered before taking charge of a suicidal teen (Table 1).

1. Establish a no-suicide contract

This contract is not a signed paper contract and is a not legal protection for the practitioner. It is, rather, a way to actively engage the teenager in

treatment and is an opportunity for the patient to promise to find alternatives and support. The efficiency of these promises depends on the resources available for the teenager. First of all, in presence of the parents and the clinician, the teenager must promise to avoid self-harm, to contact his/her parents or the practitioner in the event of a suicidal impulse. The clinician must provide 24-hour backup, and must have an alliance with the teen and family to do so. This process gives the clinician a good idea of the teenager's ability to engage or to oppose.

2. Secure compliance to treatment

It is well known that teenagers are not very compliant to treatment. There is, therefore, a high risk they will act on suicidal impulses. Improving hope is a good strategy to adopt to improve the outcome. The practitioner may include the psychopathology, with psychoeducation about depression, anxiety, *etc*., in explaining the biological causes and treatment. When a practitioner understands the teenager's difficulties in a developmental way (identity formation, separation from parents, need of friends, *etc*.), the teen is better engaged. It is very important to explain a short-term plan with realistic and attainable objectives. Another appointment must be given in a short period, and significant adults must be involved for support at school and at home. The teenager must be able to contact his/her medical practitioner at any time in the week and explanations must be given for any emergency room visits.

Take-home message

- The medical practitioner's main role with a suicidal teen is to evaluate the suicidal risk.
- Suicidal risk is well-evaluated by looking at the intention to die, the child's psychopathology, available resources, family environment, and school functioning.
- A global picture of the youth and his/her environment will help determine the necessary level of care and focus of the treatment.
- Involvement of the family is critical to treatment outcome.

3. Treatment of the psychosocial factors & psychopathology

Most suicidal teenagers suffer from depression. Cognitive behavioural therapy and interpersonal therapy are effective in treating depression. Often, an antidepressant may be added according to the

Suicidal Teens

What happenned to Katie?

Initial examination

You should first eliminate the major depressive disorder. In the individual meeting, sadness, guilt, hopelessness, as well as the neurovegetative symptoms, should be found. An anxiety disorder should be suspected, due to her complaints of dizziness, stomach ache, and nausea. School phobias should also be explored. Attention deficit disorder must be evaluated and any learning problem examined. You should also eliminate a hormonal disorder. Question the substance abuse and conduct problems which are often seen with depression.

Meeting the parents

After seeing Katie alone, you meet her with her parents to explain the psychiatric disorders affecting Katie. You understand that Katie is a sensitive girl, who has poor self-esteem, lacks social skills and the ability to resolve problems. With the parental discord, and the mother's sadness and irritability, Katie felt rejected and burdensome. She would like to alleviate their preoccupations. In fact, the mother is quite depressed as well. Because of her individual difficulties, Katie was not able to find good strategies, so she turned to the tough kids at school to get support and friendship to replace the usual support provided by her parents. You explain the role of neurotransmitters in the brain and the development of depression. You provide understanding for Katie's suicidal thoughts and her desire to stop the actual problems in the family.

Follow-up

After the visits, the parents and Katie are emotional and communication is restored between them. You elaborate on the no-suicide contract, giving a week off school, an appointment in the next seven days, and the clinic and emergency room numbers. You prescribe an antidepressant and give her something to sleep. You refer the parents to a social worker for conjugal and family therapy, and the mother to another medical practitioner.

You contact the school psychologist and recommend psychological testing for Katie to better understand her academic difficulties. Katie is good in sports, so you encourage her to get involved in a team to improve her social abilities. Group therapy can also be offered. You avoid giving her a prolonged withdrawal from school, but you may lighten her school classes. For teenagers, it is better to keep a structure to avoid regressive tendencies.

After the evaluation, hope and communication are restored and the suicidal risk becomes manageable.

intensity of the depression. The presence of comorbidities increases the suicidal risk and the resistance to treatment. All of these must be addressed specifically. The psychiatric problems of the parents must also be treated.

Both the family and the child must be considered. In the evaluation, improving the relationship between the parents and the child will secure support for the teen at home. The family must be supported in its difficulties, and factors of neglect or potential abuse must be recognized and acted upon (family therapy or notifying social services). A psychoeducative approach will help to ease the parents' guilt. Always involve the family in your treatment of a suicidal teen.

The suicidal teenager must learn to control his/her temper and impulsiveness, and to regulate his/her emotions. This can be achieved with a cognitive, interpersonal, group, or family therapy. Cognitive distortions must be worked on and a

sense of control re-established for the patient. To improve the hopelessness, it is good to look at what did not work in the past and establish easily attainable and realistic objectives. Social difficulties must also be addressed.

School problems are a very important aspect to consider during treatment and support. Neuropsychological evaluations may be useful to understand the learning problems of the child, and attention deficit disorders must be treated. Harassment in school should be dealt with by the school, and a resource person at the school may be specified.

4. Determining the level & intensity of care

The greater the suicidal risk, the more intensive and restrictive the treatment will be. A referral to child psychiatry for hospitalization or treatment is considered according to the following:

- suicide characteristics (active plan with high lethality mean, profound moral distress), combined with a severe psychiatric disorder (depression, bipolar disorder, substance abuse, psychosis);
- characteristics of the child (hopelessness, aggressiveness, hostility which disturb the therapeutic alliance); and
- past history of suicide attempts and failure of past treatment.

Many family problems will perpetuate suicidal thoughts and these parents may not be able to protect or support the child. CME

The clinician should provide 24-hour backup.

Suggested Readings

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