On Counselling and Support for Suicidal Children, Adolescents and their Parents

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Actually committed suicides among children are extremely rare despite the frequent occurrence of remarks such as “I wish I was dead”, “I will be dead” and “I don’t want to live any more” from children under the age of ten which frequently prompts the arrangement of an appointment with a paediatric specialist. The majority of children have relationships with parents, siblings and other relations which are a sufficient guard against suicidal tendencies and prevent them from any contemplation of killing themselves. It is nevertheless still important to recognise the internal suffering on the part of these children which prompts them to utter remarks such as those listed above.

In adolescence, the tendency for suicidal comments, attempted and committed suicides becomes more frequent with increasing age. A difference should be made between committed suicide leading to death and suicidal thoughts, remarks, threats and attempts. The latter can be further subdivided into milder or more serious or within the context of a danger to life from appellative to serious.
Within the context of secondary prevention, the favourable experience of treatment in adolescence is a contributory factor for the prevention of subsequent suicide attempts with a lethal outcome. Numerous adults will return to consultation or therapy after a period of many years having had positive experiences with relevant professional support during childhood and adolescence.

In paediatric and adolescent medicine, the prevention of a suicidal act has the utmost priority. The decisive factor here is a sustainable relationship between the child and the practice personnel and doctor right from initial contact with the individual.

32.3.1 Frequency of attempted suicide

There are no official statistics for attempted suicide. It is in fact exceedingly difficult to record all attempted acts of suicide because only a certain proportion of these acts become known, i.e. those which have to be treated in hospital. Numerous attempted suicides either only become known to family doctors or advisory centre staff or even remain completely untreated and are therefore not included in statistics.

It can be estimated that within the age-group up to 25, there are ca. 20 – 30 times as many attempted suicides as completed suicides. This translates into an approximate annual figure of around 25,000 attempted suicides in Germany within this age-group.
Attempted suicide always implies the existence of a stress situation and must therefore always be taken seriously, irrespective of how far the attempt itself was taken. Measures should always be initiated to ease the burden of stress. It is generally considered that the rate of attempted suicide is highest in young persons, females being three times more likely to undertake attempted suicide than males.

32.3.2 Frequency of suicides committed

Any statistics on suicides must be treated with caution: it can be assumed that a large number of suicides are not recognised as such and therefore not registered. It is likely that many suicides are concealed under the headings of car accidents and drug-related deaths. Generally speaking, males are twice as likely to die from a suicide attempt as females.

In the Federal Republic of Germany (old and new federal states) in the year 2002, a total of 11,163 persons (14.5 /100,000 inhabitants) took their own life (source: German Office of Statistics)

Of these,
0 persons were younger than 10
25 persons were aged 10-15
314 persons were aged 15-20
436 persons were aged 20-25

With an annual total of 11,163 suicides in Germany, it becomes clear that – in contrast to attempted suicides (32.3.1) – a substantially larger proportion of committed suicides are undertaken by adults. Suicidal thoughts however frequently originate during childhood and adolescence. The prevention of suicide therefore means: favourable experiences in coping with crisis situations at an early age.

32.3.3 Bereavement following suicides within personal circles

The modestly calculated statistics of 10 affected persons within the direct circle of each suicide victim produces in an annual total exceeding 100,000 bereaved persons as a result of committed suicides. Within a recording period of 50 years, this means that a minimum of 5 million people in Germany could be suffering in a wide variety of ways from the consequences of a suicide within their personal circle.

Bereaved persons frequently go to their doctor with physical symptoms. Talking through the stress created by a suicide within the family brings relief and can contribute to the reduction of future suicides. The accompaniment of bereaved brothers and sisters is imperative. Siblings frequently suffer for substantial periods from their own feelings of guilt or experience the suicide as understandable and also an option as their own solution for conflict. The grief reactions of their parents can make the siblings feel less loved or even rejected.

32.3.4 Procedure with suicidal tendencies

“It is normally difficult to make an initial assessment of the situation of a previously unknown person. It has proved to be successful to find out more about at least five different aspects of daily life to be able to understand you and your situation better. These aspects are either vital for the satisfaction of individuals or contribute significantly to the general mood. Is it OK for you if I briefly sketch out these five aspects and then we’ll take a look at how you see your situation in the light of these individual aspects? It is after all about…”

Crisis consultation can sometimes be somewhat chaotic and participants are seldom calm and structured. It can however also transpire that these young persons are unnaturally calm and silent. The aim is the communication of a sense of calm and hope for these individuals. This requires an ordered and systematic approach. The chief objective is to make sure that the young person comes back for a second consultation and is in the meantime able to achieve a certain internal distance to their wish to die. Alternatives to suicide can be considered with time.

Essentially, the examining doctor is looking for definable partial areas, as in a physical examination, which can be talked through simultaneously or successively. This enables an initial picture of the situation to be made within ca. 15-30 minutes and the communication of competence and interest in the situation of the young person. Here it is important that the individual understands the motives behind each question.

32.3.5 The five essential aspects of life

1. Relationships: partner, father, mother, siblings, other relations and friends.
2. School/professional training/profession /career
3. Living conditions: bedroom and living rooms, disorders, travelling routes
4. Finances: pocket money, income and debts.
5. Health, pain, physical experience and well-being. “The objective here is to acquire knowledge about special events and possible origins of stress, but simultaneously about areas which are acceptable or even favourable. This is where options for action could be identified of which the individual is no longer aware.”

When approaching questions on criminal acts, debts, drug consummation or sexual orientation (homosexual males have a higher suicide risk) and experience of violence and abuse, it is helpful to assure the individual that these questions are asked to all young persons within these age groups and that all information will be handled with the strictest confidentiality.

32.3.6 Risk assessment

The diagnosis of suicidal tendencies also has additional therapeutic implications.
Similarly to a multimodal, multi-track diagnosis and therapy, the findings can be examined simultaneously in the light of eight aspects within the framework of risk assessment and treatment planning phase.

1. Building up a relationship and achieving acceptance. Right from the point of registration, attempts should be undertaken to break down barriers in order to succeed in making contact with as many young persons suffering from a life-crisis as possible. An initial consultation without the necessity for complicated forms, consent form to be signed by parents, notification of medical insurance company or the recording of personal data such as name, address and telephone number of parents would be ideal. The young person should only have to state by telephone or at the reception desk that he or she would like to speak to the

doctor. Information can normally be compiled during the consultation. Many young persons rightly fear that what they tell the doctor could be discussed with parents or other individuals (e.g. teachers, policemen and youth welfare offices). These young persons prefer to give their own mobile telephone number rather than the home telephone number of their parents. Long waiting times in the waiting room should be avoided, as patience and composure is normally substantially reduced or non-existent in suicidal adolescents. Extensive waiting times could be construed as a lack of interest or time on the part of the doctor and adolescents could feel a sense of shame from being observed in the waiting room and simply leave.

What is important is that the sense and purpose of consultation in a crisis situation should be explained to adolescents alongside details of medical intervention (duration, regularity and possibilities of help).

The rule of confidentiality should be explained thoroughly: “If we discuss problematic or difficult situations here, this information is protected by a law of confidentiality. Other persons (such as parents and teachers) who wish to find out more details must understand that it is not possible to provide this information should this violate medical confidentiality. We are attempting to help young persons such as yourself to take the matter in your own hands and the doctor will not help if he or she passes information on to third parties. It is however a completely different matter if you yourself request us to talk to a specific person.”

During consultation, interruptions such as signing prescriptions, interim questions asked by medical staff, telephone conversations, “just going out for a short time”, etc. be avoided at all cost. Adolescents in suicidal crises are frequently easily offended and quickly feel themselves devaluated. The underlying medical approach should be compassionate and interested. After the question has been addressed as to why the individual has come to the consultation, it should then be explained how attempts to help him or her will be undertaken (see above with Procedure with suicidal tendencies, five aspects of life) and whether this approach is acceptable for him or her. An approach involving immediate confrontation and comments on any abnormal behaviour on the part of adolescents or other individuals should be avoided and any form of moralising or humiliation are just as counterproductive as over-impulsive comforting, immediate suggestions or pieces of advice. This could be interpreted by the adolescent as a know-it-all attitude and “moving on as quickly as possible” or feel himself or herself as inferior which should be strictly avoided under the threat of suicide. Comprehension means showing understanding: the adolescent should come to his or her senses independently and not be forced into this process by the consultant.

“I would like to be able to comprehend and understand who displayed what behaviour in what type of situation and what happened then.”

2. Finding out the reasons for the suicidal tendency. “You said that you have no idea why you attempted to commit suicide. Could one of the (below-mentioned) reasons be possible? I would like to understand how you felt in this situation and what you felt or thought at the time.” Seen from the outside, attempted

suicide often appears to have been undertaken "without real justification" and the trigger point is frequently considered as trivial, particularly by adults. For the understanding of suicidal tendencies in adolescents, it helps to differentiate between triggers and underlying or more profound causes. Triggers are the events immediately preceding the suicide attempt which act as the proverbial last straw which breaks the camel's back. There are many popular sayings used as a metaphor for these types of situation.

"Numerous persons experience a crisis as the last straw which breaks the camel's back, a volcano erupting, a shot being fired or being unable to continue carrying a heavy rucksack alone or withstand its considerable weight. Could one of these examples be appropriate to what you felt?" The reason why a specific event such as a prohibition which would be acceptable some individuals is experienced by others as unreasonable often initially appears to be incomprehensible until the underlying causes and/or additional stress factors can be identified. It is imperative to determine the subjective reaction on the part of the adolescent, even or particularly when this appears discrepant to an "objective and sensible" experience.

Possible events in the sense of risk factors for suicide are:

1. Separation
2. Insults
3. Failure at school or work
4. Member of a fringe group (homosexual, foreigner etc.)
5. Moving house, change of school or loss of habitual objects, behaviour etc.
6. Mobbing or bullying
7. Criminal career
8. Traumatic experiences: deaths, accidents, experiences of violence such as abuse, mistreatment, serious neglect, etc.
9. Psychiatric illnesses (schizophrenia, eating disorders, personality disorders, depression: see Chapter 32.2)
10. Suicide attempts or suicides committed within the adolescent's environment and
11. Media representations of suicides which always harbour a great danger of imitation (Werther effect).

3. Consideration of oppressive family dynamics

The following aspects of family life could substantially increase the risk of suicide and should be taken into consideration in the assessment of the general situation. The superfluous child/ adolescent: numerous children born in quick succession can trigger off thoughts of suicide, as the individual adolescent could (falsely) presume that he or she is unwanted or unwished. Parents who are so absorbed with a sick or handicapped child or cannot come to terms with the loss of a child can trigger off fantasies in the healthy child that the parents would have preferred him or her to have died in the dead sibling's place.

Intense assignment of guilt to child

Adolescents also frequently feel a sense of joint guilt for the illness of a sibling, the death of family members or the illness of a parent. Children also often have feelings of responsibility or even guilt for the unhappy marriage of the parents. Careers which have been interrupted by one of the parents due to their children, unfulfilled hopes of their own lives or those of their children can also create substantial feelings of reproach.

Role models, family tradition of pessimistic attitude to life

One family member is depressed and/or suicidal, repeatedly threatens with suicide or collective suicide (i.e. taking other with him/her into death), often over a period of several years. Suicidal tendencies then become a permanent issue within the family. The creation of myths concerning tragically failed ancestors is not uncommon in certain families ("he is just like uncle X who was also never satisfied with his life and committed suicide"). In cases of conflicts of loyalty against a background of rowing parents, separation and divorce cause children and adolescents to consider their own suicide to escape from these disputes and avoid having to decide for and therefore also against one of the parents. Symbiotic bonds: adolescence always entails a process of detachment from parents

The principle attitude of all parties is ambivalent. The adolescent is either afraid of leaving the parent(s) on their own or feels him-/herself abandoned by a previously close parent. An example is a single mother who after a substantial period of living alone with her son enters a new partnership or decides that it is time the son became more independent. The adolescent son feels betrayed or rejected and develops suicidal tendencies, thinking that he conflict could be solved by a one-sided radical relationship separation through suicide.

"Life as an adolescent is also like having an "old shoe" which is too small and pinches considerably, without having found a new shoe. This means that both parents and children constantly oscillate between their increasingly dissatisfactory former behaviour habits and new behaviour patterns which have not yet had sufficient practice to become familiar and are therefore also unsatisfactory. Both sides then reproach each other with accusations of ingratitude, lack of respect and inconsequentiality in their behaviour."

Violent atmosphere, maltreatment, abuse and neglect

In families where maltreatment, abuse and neglect are rife, the situation creates multiple burdens which can lead to suicidal tendencies in victims of all ages. These victims for example frequently see themselves as being responsible for the treatment they receive, are ashamed, sad about the negative situation, are envious that others have better lives, are angry at the perpetrators or experience feelings of helplessness regarding the apparent hopelessness of the situation. Adolescents who visit paediatric or youth health clinics are frequently still experiencing maltreatment and abuse which makes talking openly about the situation virtually impossible. In these cases, it is vital to undertake an extremely careful and sensitive

approach without however giving the impression that these topics are not to be mentioned. “I would now like to ask you a few questions which could have relevance for persons within your age-group which I ask all young persons. This covers subjects which can be particularly difficult to talk about, but if these situations do exist, they could necessitate radical changes. The discussion of these topics falls under the obligation for medical confidentiality. Is that OK?”

If the adolescent gives his or her consent, the start can be made by approaching the subject of drugs and the consumption of alcohol. This is followed by the topic of criminal acts such as shoplifting or debts originating from mobile phone bills, internet charges or purchasing in instalments. If it is possible to talk openly about these subjects, the area of sexual experience and contacts, both voluntary and involuntary, can also be approached.

4. Understanding the motives of attempted suicide

Suicidal acts are often performed out of a combination of different motives which can either be surmised from the situation and current burdens of a particular individual or be stated by the adolescents themselves. Acute factors are far more frequently named rather than the underlying motives which would not always be initially tangible. Frequent motives increasing the risk of suicidal tendencies include:

1. Putting others in the wrong, making them feel sad and assigning blame.
2. Revealing one’s own helplessness and despair. This can also be intended as an appeal for help or for some form of change to be made.
3. Attracting attention and devotion to oneself.
4. Request for help and support
5. Test of loyalty (“will they still side with me?”)
6. Revealing the significance of another person (“I can’t live without you!”)
7. Retreating from a conflict, finding peace and freedom from all strains
8. Avoiding being forced to confront impending disaster or rejection
9. Torturing thoughts such as avoiding one’s own accusations of guilt
10. Thoughts about being dead and hoping for a “better afterlife” or closer association with other deceased persons. Suicides or attempted suicides always create a high risk for imitators.

5. Recognition of signals for serious crisis situations and risk of suicide

For surrounding persons, acts of suicide often come “out of the blue”. A closer look will however reveal that signals have already been sent out in most cases which could be perceived as symptoms and are diagnostically indicative.

Conspicuous behaviour

- running away/ absence from school or vocational training; drop in work standards
- social withdrawal accompanied by loneliness, listlessness and loss of interest
- significant alteration of behaviour (or inexplicable calmness)
- physical self-neglect or the opposite extreme
- changes in eating habits and psychosomatic symptoms

Comments

- vague or concrete comments on the subject of suicide
- concealed, indirect or coded indications relating to the end of life, e.g. comments that he/she will no longer be around at Easter/Christmas or will not be taking part in a school trip anyway.
- questions and/or "neutral" discussion about lethal substances
- utilisation of signs, symbols and colours associated with suicide, e.g. black crosses, graves, gallows and illustrated scenes of death
- words, utterances and poems which are associated with suicide
- farewell letters
- comments such as "a right to commit suicide" or "everyone should die when she or he wants to"

Practical preparations for suicide

- e.g. collecting tablets, test visit to a bridge, procurement of vacuum cleaner tube to transport exhaust fumes into car
- donation of personal gifts in the manner of the execution of a will

6. Establishment of emotions in adolescents

The following emotions and reactions are typical for suicidal individuals and can be established in conversation. If the adolescent is unwilling to describe emotions or only provides vague indications, typical reactions of others can be suggested. The adolescent should have a feeling of relief and feel understood.
"If you recall this situation, what is or was going on in your thoughts: what were your experiences or feelings? … Was there perhaps a feeling of …?

- helplessness and hopelessness
- shame or guilt
- having been insult or put-down
- disappointment, rage and anger
- suspicion and envy
- anxiety, doubts and mistrust
- grief and resignation

- emptiness
- fatalism
- ungrounded hopes
- humiliation and embarrassment
- idealisation and devaluation

7. Recognition and utilisation of emotions as a helper

The person examining the child will frequently experience emotions of conflict such as anger or helplessness while discussing the emotions of the adolescent or other participants. The list of possible emotions corresponds to the above list for adolescents. Impatience, anger and the tendency to belittle emotions are particularly dangerous in the examiner. Easily offended adolescents could feel themselves rejected or not taken seriously. Many young persons also tend to belittle feelings to avoid causing problems or because they hope to be able to escape from the consultation situation as early as possible as they feel misunderstood by the doctor. Even if the doctor is able to build up a good relationship with the young person, there is a danger of belittling the graveness of the crisis situation.

8. Making a diagnosis; elimination of differential diagnoses

Even if an exact diagnosis is hard to establish, it is vital to undertake a diagnostic isolation procedure. Frequently it is possible to derive an understanding for the situation and suicidal tendencies through differential diagnoses. Therapeutic measures can frequently be better derived through this process. Possible diagnoses accompanying a frequently established adolescent crisis include:

Acute stress reaction (ICD 10: F43.0),
Post-traumatic stress disorder (ICD 10: F43.1),
Excessive demands at school, partial disorders (e.g. dyslexia (ICD 10: F81.0),
Eating disorders (ICD10:F50),
Personality disorders (ICD 10: F60),
Depression (ICD 10:F32) (also see chapter 32.2),
Schizophrenia (ICD 10: F20).

32.3.7 Practical steps– intervention

A core problem in dealing with adolescents with suicidal tendencies is succeeding in communicating with these individuals. If the adolescent talks to their parents or other adults such as relations, teachers, doctors, trainers etc, this makes everything much easier as the individual is seeking help and advice. What is much more frequently encountered is that these adolescents provide signals that they require help through their behaviour or psychosomatic illnesses, i.e. they “pull the strings of the puppets”. During puberty, a period characterised by wrestling for one’s own identity, detachment and independence, adults are frequently viewed as know-it-all and laying-down-the-law instances who do not understand these young persons.

For this reason, parents are often the last to be taken into confidence. All other adults who become involved in the situation on request of parents will also be quickly rejected if the adolescents do not have the impression that they are well-meaning. If adolescents draw attention to themselves through negative behaviour, it is important to address this matter without any accusations.

For example: “I have heard that your school marks have gone down in the past few weeks – is that true and do you share this impression?” “I am surprised and worried and wonder what the reason for this could be. Do you have an idea?” What is important that an answer playing down the situation and a cool façade do not communicate discouragement or anger.

Numerous individuals in acute crises hide their despair, anger and grief behind a seemingly arrogant, aggressive or cool exterior. Profoundly self-confident or positive behaviour can also be jarring. Here it can also make sense to comment on recognisably contradictory behaviour or communicate the relevant concerns of other persons: “How would it affect you, what would you think and do then if you were in my position?”

32.3.8 Questions aiding better understanding

- Where do stress situations occur and in which areas of everyday life: relationships, school, at home, financial aspects or in physical/health issues? (see chapter 32.3.5.)
- Who is suffering: only the adolescent or also siblings, girlfriend or half the class?
- What is the individual suffering from?
- For how long: hours, days, months, years and
- How long per day, week, month or year?
- What is the degree of suffering: “slight, bearable, increasing, intense, unbearable and on no account bearable”

Adolescents frequently tend to say too little rather than too much. Questions on the situation, behaviour and consequences/results are appropriate here. Adolescent: “I feel bad!” (result)
Doctor: “In what situation do you feel bad? (situation) What do you then do? What do the others do? What did you do before? (behaviour) “What happened then? (new result) “How did the situation change? (new situation) “How could you act differently? (new behaviour) “What result could this have? (new result)

32.3.9 Dealing with the taboo topic of “suicide”

It is vital to take the problems of young persons seriously, even if you yourself possess a substantially better toleration of frustration. Bad school marks do not appear in themselves tragic or self-inflicted and an unhappy love relationship is easy to snigger about, although these problems could be existential concerns of the individual. It is important to express sympathy without over-commiserating and communicate optimism without attempting to gloss too lightly over a situation. It can also never be determined whether

the reasons supplied are not concealing other more serious burdens and traumas such as violence in the home, neglect and abuse. Once worries, anxieties or burdens have been formulated, the subject of suicidal thoughts should be approached:

e.g. "…after all that you have talked about, have you ever had thoughts of not being able or wanting to live like that any more?" If the answer is "yes", you should not be alarmed, but continue to address questions calmly on how concrete these suicide plans had already been pursued. There adolescent is at a high risk of attempting suicide if he or she has already selected a location for the act or procured tablets or a vacuum cleaner pipe to divert car exhaust fumes. It is false to assume that mentioning the possibility of suicidal thoughts will be instrumental in providing the adolescent with ideas of suicide. A large proportion of adolescents have already entertained thoughts of suicide and mentioning the subject provides them with the first opportunity to talk about these thoughts and find alternatives for suicide. The adolescent will be drawn out of his or her isolation through open communication. What is important here is to make clear that suicidal tendencies are a generally familiar topic, frequently though about and alterable. There is always a part of an individual which desires to continue living and a part which no longer wishes or is able to carry on living. Suicidal adolescents seldom really wish to be dead, but instead frequently simply do not wish to continue living as previously (see motives)

Negative wishes of taking a break in the sense of ending life to achieve final peace must be countered by life-confirming arguments. Positive wishes for change should be supported, for example by suggesting that the individual could live differently in the future. How could life look like in six months, a year, five years or ten years? Are there positive aspects of life?

32.3.10 Dealing with frequent threats of suicide

Frequently recurring threats of suicide are also not infrequently initiated to enforce the implementation of wishes and/or to avoid negative consequences. This places the environment under pressure and triggers off worry and anger in equal degrees. Unfortunately, it is not possible to assume that an individual making frequent threats of suicidal thoughts will not actually take his or her own life. This has repeatedly been falsely asserted and unfortunately disproved by a subsequent suicide. Should suicidal remarks or threats be ignored, this can trigger off a vicious circle which can end in real suicide. If on the other hand all the wishes expressed by the adolescent are fulfilled, this can also lead to attempted suicide.

It is best to outline this dilemma with the individual, whereby it is important here not to display anger or aggression. The knowledge that the adolescent's actions could additionally or specifically be motivated by a profound internal crisis situation such as problems relating to self-esteem or anxiety makes it easier to limit the extent of feelings of anger.

32.3.11 Limitations of prevention of suicide in outpatients

A crisis discussion on suicidal tendencies can place the doctor in a difficult situation which explains why numerous GPs are reluctant to address the decisive topic of suicidal thoughts in consultations with both adults and adolescents, despite the fact that it is known that a dramatically high proportion of persons committing suicide consulted a doctor immediately prior to their suicidal action.

In the presence of the following conditions, admission of the patient to hospital should be considered:

1. Considerable self-endangerment (which cannot be reduced through crisis intervention)
2. Considerable danger to others (e.g. aggression and dangerous behaviour)
3. Following an incidence of attempted suicide (medical diagnosis, continuing suicidal tendencies)
4. Psychopathic diagnosis with profound depression, delusional symptoms, agitation, disorientation and insufficient communicative contact
5. Problematic social situation with insufficient support resources and an overtaxed and exhausted social environment. The removal from a critical social environment appears to be necessary as an interruption.

Procedure:

1. Do not permit yourself to be provoked or made to appear helpless
2. Consultation and affirmation e.g. with educational or family advisory centres, drugs or school counselling, child and adolescent psychiatric units and clinics
3. Attempt to persuade the patient to seek admittance to hospital of his own free will
4. If no meaningful communication is possible, arrange admittance without haste
5. If in a life-threatening situation, do not hesitate to contact emergency doctor or police
6. Inform the persons responsible for custody. Clarity over the priority of saving life

32.3.12 Crisis intervention – summary:

1. Build up a relationship: focus of discussion on the current living situation
2. Clarify this situation: discuss topics openly, accept despair as a possibility and do not attempt to address this issue negatively
3. Withstand your own feelings of perplexity or helplessness
4. Make the difficult situation into a major topic: summarise the stress factors
5. Address possible suicidal thoughts: “…after all that you have talked about, have you ever had thoughts of not being able or wanting to live like that any more?”
6. If suicidal thoughts are confirmed, ask about concrete plans
7. Vicariously express your own hopes and do not play down the situation
8. Confrontation with your own view of the situation: identify discrepancies
9. Motivation to involve other persons in a position of trust
10. Arrange further consultations and/or clarify further transfer

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Service

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Beratungsstelle NEUhland in Berlin: www.neuhland.de

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