

Oakleaves

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The facts about teen suicide

by Daniel Kinsey, M.D.

Distinguishing between self-injury and suicidal behavior in teens is often difficult. Completed suicide is rare in childhood, but starting at about 13 years, the rate begins to increase. By the end of adolescence, the rate is on par with rates of suicide in young adults. Although girls have a higher rate of suicide attempts, boys have a higher rate of suicide completion, and whites display higher rates than blacks.

In this country, suicide accounts for a higher proportion of all deaths among adolescents than among adults, in fact, it is the third leading cause of death among adolescents. Rates of both suicidal ideation and attempts are surprisingly high among adolescents. The Youth Risk Behavior Survey, which received completed questionnaires from 13,953 students in grades 9 to 12, found that 16.9 percent of adolescents considered suicide, 8.4 percent attempted suicide, and 2.9 percent made an attempt that required medical attention. Comparing this high rate of suicidal ideation to the rate of completed suicides reveals that for every 2000 youth who have suicidal ideation, there

is only one completed suicide. This high ratio implies that in adolescents, the presence of some suicidal ideation is a very weak predictor of who will actually commit suicide.

What can be done in terms of prevention? Research has shown that heightened surveillance through peer reports is not very effective. Because so many youths report some suicidal ideation, screening has good sensitivity but very low specificity. Effective screening requires numerous resources to follow up with the high numbers who report some suicidal thinking, and resources are rarely available to make this an effective approach.

As with adults, there are multiple risk factors at the individual, family, and social levels. But as with adults, no single constellation of risk factors allows for an accurate prediction for suicide for a particular person. Of the individual factors discussed in the literature, a history of a recent attempt is the most potent predictor, especially in boys. Therefore, asking about suicidal thinking and attempts should always be a component of the initial assessment of an adolescent or depressed child.

Although suicidal ideation is more common among adolescents than adults, ideation is more likely to be denied when asked about in this population. In assessing the intent following a suicide attempt, The Youth Risk Behavior Survey suggests assessing four main components: wish to die, preparations, concealment, and communication.

The wish to die component involves examination of the underlying intent of the suicide attempt. What is the person's expectation with regard to dying, and what is the lethality of their chosen means? Adolescents tend to misjudge the lethality of means more often than adults, so it is important to ascertain the youth's thoughts about how lethal he thought the means would be, rather than relying solely on the clinician's medical knowledge about the actual risk of dying from, for example, a particular medication.

The preparation for the attempt can give further clues into the individual's intent: the saving up of pills, for example, or saying good-bye to various people can help with the assessment. Some people will plan a

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Oaklawn Education Events

Oaklawn is committed to providing education events for professionals and the general public and to collaborating with other community agencies. Information about education events can also be found on our web site at www.oaklawn.org.

Professional training events

Pathways from Childhood Aggression to Adolescent Violence

Speaker: James Garbarino, Ph.D., director of the Center for the Rights of Children at Loyola University, Chicago

When: Friday, November 7, 2008, 8:00 a.m.–3:00 p.m.

Where: Matterhorn Banquet and Conference Center, 2041 Cassopolis St., Elkhart

Cost: \$60

CEUs: 5.0

Who should attend: This seminar is designed for professionals who work with children, including probation, department of child services, school counselors/teachers/nurses, therapists and social workers, pastors, and others interested in the topic.

Description: One of the important developmental starting points in understanding violence is that physical aggression is essentially universal in infants. Early trauma creates risk that this early aggression will coalesce into violent behavior in adolescence. The experience of abuse sets the child up for the kind of “risky thinking” that leads to chronic patterns of aggression, bad behavior, acting out and violating the rights of others that can lead to a diagnosis of “conduct disorder.” If no intervention occurs, this pattern of childhood conduct disorder becomes the entryway into adolescent delinquent and antisocial violent behavior. The presentation is based upon the author’s books *Lost Boys* (NY: Free Press, 1999) and *See Jane Hit* (NY: Penguin Press, 2006).

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method avoiding discovery: this may involve timing of the attempt or selection of an isolated location. The final aspect of intent is communication: some will tell others directly or indirectly of their suicidal thoughts, or write a note, and it is useful to learn what was communicated.

Suicide attempts are often precipitated by stressors such as separation, loss, and incarceration. A 1993 study found that 70 percent of adolescents attempting suicide had a stressor but half of those stressors occurred in the preceding 24 hours. This reflects the impulsivity of adolescents, but it also highlights the very short window available for intervention between the stressor, which is often unpredictable, and the attempt.

There are also some major differences with regard to individual diagnosis between adolescents and adults, although as with adults, depression is the most common diagnosis. Psychotic disorder is significantly less common among adolescents than among adults, and disruptive behavior disorders in youth increase the risk. Perhaps most importantly, the combination of depression and anxiety (specifically generalized anxiety disorder) or depression and a disruptive disorder (primarily oppositional defiant disorder) have been shown to greatly increase the risk of suicide. The severity of impairment of these disorders correlates with the degree of risk, indicating the need for complete and accurate diagnosis of these psychiatric disorders among adolescents.

When assessing and diagnosing adolescent suicide risk, family factors are crucial. This side of the equation is more important among adolescents than among adults because adolescents have undergone their entire development interacting with their family. These family (and genetic) factors can also be protective, and this is a critical area for intervention. Furthermore, in managing an adolescent outpatient, the ability of family members to observe and to be protective needs to be assessed. Social factors among adolescents also differ in comparison with adults. Contagion effects

are generally more powerful, and suicidal ideation is often communicated to peers.

There are four major steps in treatment: protection of the patient, continuing risk assessment, amelioration of risk factors, and enhancement of protective factors. Youths for whom an outpatient treatment plan does not sufficiently reduce risk need hospitalization. Because parents can usually consent to hospitalization and override an adolescent’s wish not to be hospitalized, “refusing” adolescents can usually be hospitalized without resorting to civil commitment. Treatment plans for suicidal youth use a variety of modalities to reduce risk and ameliorate risk factors.

There has been some focus on medication treatment for many of the underlying diagnosis and symptoms, but there is not one medication specifically targeting suicidal or self-injurious behaviors. Several different medication treatments focus on depression and anxiety symptoms, but these medications take time to work and are not going to prevent the behaviors.

A suicidal adolescent needs a treatment plan that goes beyond just psychopharmacology. Psychosocial treatment has been shown to be effective for depression, but little research has been done specifically on its effects on suicide. One study found that multi-systemic therapy was more effective than hospitalization in reducing suicide attempts, and another found that dialectical behavior therapy (DBT) can be effective. Work with the family is important both to affect the patient directly, but also as an important source of monitoring the patient, providing information to the clinician, and directly intervening if a high risk situation arises.

More than 50 percent of psychiatrists have experienced the death of a patient by suicide. For many of us, suicide represents the most feared outcome of a patient’s mental illness and makes managing suicide risk critical to everyday practice. Unfortunately, we have little ability to predict suicide. There have been few definitive methods to determine who will and who will not attempt or complete suicide. The

purpose of a suicide assessment, then, is not to predict suicide but to help us understand the sources of a patient's tendency toward suicide and develop an informed intervention.

Understanding why a person feels suicidal can help choose the appropriate intervention. Is the suicidal feeling chronic or acute? Are there specific ways to help reduce the feeling or reduce the access to self harm or threats? Take decisive action if the risk is imminent. Actively treat underlying diagnosis (depression or anxiety) or address the intoxication or access to drugs or alcohol, which could impair judgment. Recruit and involve the person's support system, augmented with a close follow-up plan. Work with the supports system to remove guns or knives or reduce access to pills in the home. Develop a specific plan of what to do if the individual reports suicidal thoughts, a "safety plan" can be very helpful for those who are at risk for chronic/long-term suicidal thinking or severe depression. This can include using phone contacts of friends or suicide hot lines. It may include not being alone or using specific coping and soothing awareness programs (such as DBT) to help reduce physical distress.

Childhood and adolescence are marked by rapid change and development. Effective interventions hold the promise of helping suicidal youth through a difficult period so that normal development can resume its course. Although assessment and treatment of suicidal youth is a difficult and weighty task, the rewards to the clinician of successfully helping children and adolescents return to normal functioning are high.



Daniel Kinsey, M.D. is medical director at Oaklawn.



Suicide prevention

The Elkhart County Suicide Prevention Coalition started in October 2003 as a result of a growing concern about the increased rates of suicide in Elkhart County. In 2003, Elkhart County experienced 19 deaths by suicide, seven more than the state average of 12. As a result of this concern, a collaborative effort began of many local organizations and concerned citizens. Indiana's suicide rate has been higher than the national average for nearly a decade. The Coalition meets at the Elkhart County Health Department, Lincoln Center on the fourth Wednesday of each month at 8:30 a.m. All meetings are open to the public. The Coalition provides informational programs for schools, community groups, employers, and agencies; offers information on available resources; organizes an annual walk to raise awareness and to honor World Suicide Prevention Day; and partners with Ryan's Place to offer support for those who have lost a loved one to suicide.

Oaklawn Spring Spectacular

Steven Ford will be the speaker at Oaklawn Foundation's 9th annual Spring Spectacular fundraiser on May 9, 2008, at the Matterhorn Banquet and Conference Center in Elkhart. Ford is the son of former president Gerald R. Ford and Betty Ford. In his talk is entitled "Alcoholism: My Story," Mr. Ford will share a broad range of inspirational stories, including how the family dealt with Betty Ford's battles with alcoholism and breast cancer, his own successful fight to overcome alcoholism, and the Nixon Pardon. For information on tickets for the Spring Spectacular, call (574) 537-2645.

Oaklawn reaccredited

Oaklawn recently received word that its accreditation by The Joint Commission was renewed for three years. Surveyors were on site at Oaklawn for four days in December. Certification is awarded to health care programs or services that are in compliance with all Joint Commission standards, use clinical practice guidelines, and meet performance requirements. Oaklawn president Laurie Nafziger notes that, "We seek accreditation for our organization because we want to be the best and we view obtaining Joint Commission accreditation as another step toward excellence."

Oaklawn services for youth

Child and adolescent outpatient and intensive outpatient services

For more information, contact Bonita Bontrager Schrock, vice president, at (574) 533-1234, ext. 223.

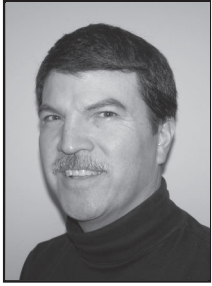
- Assertive Community Treatment for Children Bashor/Oaklawn program**
- Community Alternatives to PRTF**
- Community Partners Program**
- Family Intervention Team (outpatient/Elkhart)**
- Marilyn Avenue (outpatient/Goshen)**
- Juvenile Community Transition Program**
- Supervised Visitation**
- Traditional Foster Care**
- ASAP (Adolescent Substance Abuse Program)**
- CASS (Children's Alternative Support Services)**
- CARE (Cooperative and Relational Endeavors)**
- Treehouse Preschool Program**

Child and adolescent intensive services

For more information, contact Sharese Swafford, director, at (574) 537-2630.

- Adolescent group home**
- Therapeutic Foster Care**
- Locked/secure/PRTF residential (coed)**
- Female residential**
- Male residential**
- Adolescent sexual offender program (male)**
- Young sexual offender program (male)**

The professionals at Oaklawn



Philip Good-Elliott



Jeff Hashberger



Jessica Kindig



Joan Pontius



Sharese Swafford



Jerica Tripp

Philip Good-Elliott, M.S.W., LCSW, is a social worker in the adult and senior inpatient program at 330 Lakeview Drive, Goshen. He received a master of social work degree from the University of Michigan, Ann Arbor, and is a licensed clinical social worker.

Jeff Hashberger, M.A., is a therapist with the Bashor/Oaklawn program. He has a master's degree in counseling psychology from Olivet Nazarene University, Bourbonnais, Illinois.

Jessica Kindig, M.Ed., is a therapist with the family intervention team at 2600 Oakland Avenue, Elkhart. She has a master of education degree in counseling with a concentration in art therapy from the University of Louisville, Kentucky.

Joan Pontius, M.S., LMHC, NCC, is an outpatient therapist with the family intervention team at 2600 Oakland Avenue, Elkhart. She is also the therapist for the CARE (Cooperative and Relational Endeavors) intensive outpatient program.

She holds a master of education degree in counseling from Indiana University at South Bend and is a licensed mental health counselor and a national certified counselor.

Sharese Swafford, M.A., LMHC, has been named director of child and adolescent intensive services at Oaklawn. She was previously a program manager for the child and adolescent residential program and manager of outreach services.

Jerica Tripp, M.S., was named team leader of the traditional foster care program at Oaklawn. Oaklawn administers this program under contract with the Elkhart County Department of Child Services. She previously served as team leader of the Access Center.

Oakleaves is published three times a year and is designed to address timely mental health and addictions clinical issues as well as inform professionals of Oaklawn's services and educational events.

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