Evaluation of Suicide Risk in Adolescents

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Self-destructive behavior in the adolescent is a continuum that ranges from drug intoxications to gestures of low lethality to suicide attempts with high lethality of intent. Such behavior should be treated as a signal of long-term stress and strife.

A "psychological biopsy" is outlined for evaluation of the severity and type of perturbation. This focuses on nine areas of inquiry: the circumstantial lethality of the event; prior self-destructive behavior; depression; hostility; stress; reaction of the parent or parent surrogate; loss of communication; lack of resources; and extremes of parental expectations and control.

Adolescents under severe familial and socioeconomic stress, and with a history of acting-out behavior, often respond well to transfer to a more favorable home situation. In cases where there is no apparent familial perturbation, the physician should be alert to the possibility of severe psychiatric disorder. In either case, initial definition of the problem opens the way to a plan for management and support.

Self-destructive behavior in adolescents ranges from "kicks" or "trips," to manipulative gestures or suicide attempts, to suicide attempts with true lethal intent. Tragically, many adolescent suicides are unintentional; the victim was making a gesture but did not really mean to die. In our survey, "Suicide as Seen in Poison Control Centers," we found that 20 percent of cases admitted to a poison control center involved intentional self-poisoning.[1,2] Suicide attempts may account for 12 percent of all Emergency Room visits.[3] This represents a public health problem of the first magnitude. While death from major diseases in children and adolescents has been declining, suicide is now the third leading cause of death in young people aged 15 to 25, and second only to accidents in the white population in this age group.[4] The majority of these deaths are not suicides but pharmacologic roulette.[1] During the past decade, the abuse of drugs and toxic substances in children, and particularly adolescents, has increased enormously leaving unintentioned death, suicides, and other personal social problems in its wake, and necessitating massive antidrug and rehabilitative programs in every section of the United States. It is the purpose of this paper to describe a systematic method of inquiry that the primary care physician can use to evaluate the degree of perturbation for these patients.

The primary care physician is a valuable resource for the evaluation and assessment of self-poisonings, suicides, and suicide attempts in children and adolescents. He may feel ill-prepared to evaluate the lethality of intent and degree of perturbation in these adolescents, but as their frequent first contact, he can become one of the "gatekeepers of suicide prevention." Systematic examination and evaluation of these adolescents presents the opportunity and responsibility to study suicidopathic behavior and drug abuse in its most transparent form.

Assessment of Suicide Risk

We have used Shneidman's definition of "lethality" as the probability of an individual killing himself in the immediate future.[5]

LETHALITY OF INTENT

High:	Expects actions to result in death.
Medium:	Ambivalent. Plays a partial role, eg, foolhardiness.
Low:	No conscious wish to die. Plays a small role, eg, freon inhalation.
Absent:	No lethal intent.

In addition to classifying death as "intentioned," "subintentioned," and "unintentioned," instead of the traditional "natural," "accidental," "suicidal," and "homicidal," Shneidman proposed the dimension of "lethality" to cut across the semantics of attempted, threatened, and completed suicide. As a general rule, the "trip" and the manipulative act are usually of low to medium lethality. A diagnosis of a suicide attempt as contrasted to a suicide gesture implies a lethality of intent and a mature concept of death as irreversible. However, a pharmacological mishap may convert an act of low lethality to a completed suicide.

The grading of lethality of intent in self-poisoning of children and adolescents has been classified as follows: (1) accidental; (2) "trips" or "kicks," intoxication, pleasure-seeking; (3) affect reaction suicide gesture, sublethal attempt; and (4) suicide attempt, lethal attempt.

A quantitative "psychological biopsy," as used by the primary care physician or health professional, can be a valuable tool in the Emergency Room

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Table 1. Narrative Outline for Evaluation of Adolescent Suicidal Behavior

Narrative Outline of Event: Tell me what happened. (actual lethality of event) What time of day? What did you do then? Did you tell anyone? Did you think you would be found? How did they find out about it? (probability of rescue) When did you first think about doing this? (premeditation) Have you ever done anything like this in the past? Do you think you will do anything like it again?

Rating of Circumstantial Lethality:

0	1-2	3-4-5	7-8-9
None	Low	Medium	High

Narrative Outline of Family and Interactions: Tell me about the members of your family, their ages, where they live, how you get along with each. Do you think any of them uses too much alcohol or drugs? Have any of your family or close friends ever attempted suicide? Which people can you talk to when things go wrong? If you could make some changes in your life, what would you change?

Prior Difficulties, Symptoms, and Perturbation: What medical problems have you had? Have you had any school problems? Repeat a class? Dropping out? Suspended? Have you had any trouble with the police? Any trouble because of alcohol or drugs? Ever run away from home? Has a doctor ever treated you for your nerves? Have you had many problems with your boyfriend or girlfriend? Your friends? Marriage problems?

interview.[6] This "psychological biopsy" questionnaire has been of value in our program and can also be used for the prediction of recidivism in adolescent suicides.[7]

The interview can be conducted as soon as the patient is no longer in danger. (In the interim, the rescuers' view of both the immediate event and the past history should be obtained.) The adolescent should be interviewed in a private room and assured that the information will not be used against him. The physician should maintain confidentiality despite the legal pressures and parental concern. The three general areas of inquiry are outlined in Table 1.

The immediate circumstances, particularly information on the probability of rescue, are most useful in estimating the lethality of intent at the time of the self-destructive behavior. The actual event, however, is only one item in a long-term history of difficulties. The family history usually depicts great stress and strife. A history of multiple prior difficulties plus antisocial behavior usually indicates a low lethality of intent. Rage has been channeled into rebellious rather than suicidal behavior. The exceptional history, in which family perturbation appears low or even absent, is often the first indication of a severe psychiatric disorder.

The "psychological biopsy" itself (Table 2) scores nine significant areas of evaluation. Scoring of these items is derived from the initial history and supplemented by additional questions as individual circumstances indicate. The goals of the assessment are (1) diagnosis – "Is this really a suicide attempt?" and (2) definition of the nature and severity of perturbation.

The last item in the questionnaire, familial expectations and control, overlaps the ratings of stress and of parental reaction. It is included as a separate item because of its critical relationship to adolescent behavior. In adolescents evincing suicidal behavior, the pattern of familial control and demands is often at one extreme or the other. The larger group of these adolescents comes from families characterized by indifference, low expectations, and sporadic control. These young people are most inclined to act out their hostility and have frequent problems with the law. At the other extreme are those subjected to all-pervasive control and excessive expectations. Some children from this kind of family are incapable of rebellion and have more severe psychiatric disorders. The extremes of parental reaction offer some of the best opportunities for environmental change and supportive encouragement of the patient to recognize the nature of his oppression and rejection.

When this "psychological biopsy" was applied to 50 adolescents with hospital diagnoses of accident in 42 percent and suicide attempt in 58 percent, the diagnoses were changed after assessment to accident in four percent, suicide gesture in 70 percent, suicide attempt in two percent, intoxication in 22 percent, and homicide in two percent.[6]

Discussion

Using this structured interview, definition of the familial and environmental problems may lead to more effective management. In our studies, over half of the families were already known to social agencies, but the suicide gesture pointed out the crucial need for intervention. Frequently, the family situations are beyond repair. In these cases, we have found the best results in adolescents who were able to move to a more favorable home situation with a relative or friend.

A structured interview or "psychological biopsy," performed by the primary care physician, is a feasible and productive method for more insight into the problems of suicide gestures and attempts. These adolescents are the product of years of familial and socioeconomic stress, and are often unattractive, rebellious, sullen, or withdrawn. However, most will respond well to professional interest and concern. Once the problem has been opened up, plans can be made for continuing care.

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Table 2. Psychological Biopsy Questionnaire

Name: _____

Age: _____ Sex: _____ Race: _____

Socioeconomic Status: Low: _____ Med: _____ High: _____

Lives with: _____

Address: _____

Score each category as:

0	1-2	3-4-5	7-8-9	Score (0-9)
None	Low	Medium	High	_____

1. Circumstantial Lethality: (_____)

Probability of rescue_____; subject's impression of lethality_____; actual lethality_____; extent of planning_____; plans to repeat_____.

2. Prior Self-Destructive Behavior: (_____)

One or more suicide attempts/gestures_____; suicidal preoccupation_____; "accidental" poisoning after age 6_____; more than one accident/year requiring medical care_____; drug or alcohol use considered excessive by peer group_____; refuses or denies needs for health care_____.

3. Depression: (_____)

Loneliness, hopelessness, exhaustion_____; disorders of sleep _____; appetite_____; chronic illness _____.

4. Hostility: (_____)

Feelings of rage, anger, hostility, revenge_____; poor judgment, irresponsibility and impulsive acting out_____; overt belligerence, aggression, antisocial behavior_____.

5. Stress: (_____)

Chronicity and multiplicity of conflicts_____; broken or unsympathetic home_____; loss of parent, sibling, or significant other by death, divorce or "desertion"_____; alcoholic or otherwise irresponsible parent(s)_____; threat of punishment, criminal prosecution, exposure_____; concern over homosexuality_____; other_____.

6. Reaction of Parent or Parent Surrogate: (_____)

Helpless_____; indifferent_____; angry_____; punitive_____; vacillating_____; parent(s) alcoholic_____; other psychosocial difficulty_____.

7. Loss of communication: (_____)

Broken with one or both parents_____; with all adults_____; with most peers_____; all peers_____.

8. Lack of Resources: (_____)

Lack of religious ties_____; lack of availability of professional help – counselor, etc_____.

9. Parental Expectations and Control: (_____)

Subject feels parental demands or expectations beyond his capacity; feels a disappointment to parents_____; parents expect nothing from him_____; parent or surrogate demands review of friends, activities_____; refuses any discussion or negotiation of control_____; extreme indifference or neglect_____; vacillates from one extreme to other_____; expectations and degree of control divergent_____.