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Clinical judgments by mental health professionals in assessing the seriously suicidal adolescent

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Clinical Judgments by Mental Health Professionals in Assessing the Seriously Suicidal Adolescent

by

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I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Community Psychology.

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Abstract

The staggering rate of adolescent suicide attempts and deaths indicate the need for an understanding of the assessment and identification of seriously suicidal teens. According to the literature, there are two levels of lethality for danger of death due to suicide. These levels are risk for suicide and imminent danger to one's life. This study examined how experienced clinicians in three clinical settings distinguish these two groups: adolescents who are at risk and those whose lives are in imminent danger due to his or her suicidality.

Ninety (90) mental health professionals from three treatment settings, Crisis Intervention Centers, Private Practioners, and Adolescent Outpatient Programs, with 12.3 mean years experience assessing suicidal adolescents were surveyed in order to determine how they formulate clinical judgment in identifying levels of suicidal risk in adolescents. The study explored how clinicians utilized the distinguishing factors as identified in the literature in formulating clinical judgment, whether they perceived the variables multidimensionally, and how their treatment setting, theoretical orientation, and discipline effected their clinical judgments in assessing the seriously suicidal adolescent.

There were two phases to the research. Phase 1 was to ensure that the review of the literature yielded a broad and content valid domain of variables for use in Phase 2, the main data collection phase. In Phase 1, suicidologists developed a

list of factors they believed differentiated the seriously suicidal adolescent for the nonlethal suicidal adolescent. In Phase 2, clinicians rated 15 literature-generated variables on importance and frequency in differentiating the seriously from less seriously suicidal adolescent, completed a matrix on the degree to which factors occur together in the seriously suicidal adolescent, and stated in general how they assess the level of seriousness of suicidal risk in their teenage clients.

Results of several multivariate analysis of variance (MANOVA) revealed there were no significant differences according to treatment setting, theoretical orientation, and discipline on importance and frequency ratings by the participants. Multidimensional scaling procedures showed that clinicians perceive variables in three dimensions. Examination of the stimulus configurations based on the three dimensional solutions revealed that the suicidal risk factors formed three broad clusters: "Psychiatric history", "Negative Emotional States", and "Negative Life Events". Some factors consistently stood outside of the broad clusters while others did not fall into any specific cluster. Finally, one-sample multivariate t-tests disclosed there were no significant differences between importance ratings by the suicidologists on the 15 literature-generated variables, and the clinicians from the three treatment setting groups. This result suggests the clinicians surveyed do use the distinguishing characteristics as identified in the literature in making

clinical judgments in assessing the seriously suicidal adolescent. These findings, helpful for clinicians and para-professionals, underscore the validity and usefulness of ideas about suicidal adolescents gleaned from the literature and empirical research.

CHAPTER I

INTRODUCTION

The increasing rate of suicide among the young people in our society has caused a growing concern among mental health professionals, parents, teachers, researchers, and adolescents themselves (Smith & Crawford, 1986). Adolescent suicide is perhaps one of the most perplexing and disturbing problems facing the public today (Holinger & Offer, 1982). Suicidal behavior represents one of the most frequent psychiatric emergencies among children and adolescents (Reynolds, 1987). Suicide is the third leading cause of death behind accidental deaths and homicides which many researchers believe are often mislabelled suicides (Robbins & Alessi, 1985), and the rate has increased an alarming 200% since 1960 (Reynolds, 1987).

It is conservatively estimated that 6,000 young people will die this years from suicide, and that 5,000 died last year from suicide. Experts believe these figures are inaccurate because of the mislabelling of adolescent deaths and suggest that there are probably five deaths by suicide for every one that is officially reported as such (Miller, 1982), which means that upwards of 24,000 teens died from suicide in 1988. Even more astounding, 250,000 to 500,000 young people will attempt suicide this year (Reynolds, 1987). With only 8,300 adolescent psychiatric beds available in this country presently, there is tremendous concern with the assessment of the suicidal adolescent. Many youths who attempt suicide each year but survive, are often physically

and/or mentally scarred, making suicidal behavior among adolescents a major mental health and medical problem.

Not every adolescent who threatens or attempts suicide requires a psychiatric hospital admission. Each teenager who threatens or attempts suicide does require a risk assessment by a mental health professional and probably a medical doctor (Pfeffer, 1988). It is the task of the mental health professional to determine the seriousness of the adolescent's suicidal ideation, or to what extent the young person's life is at risk.

The purpose of this study was to explore how mental health professionals formulate clinical judgments in identifying levels of suicidal risk in adolescents based upon their use of factors which the literature state differentiates the high from the low risk suicidal adolescent.

REVIEW OF THE LITERATURE

To many adults it seems paradoxical that a teenager endowed with the potential and excitement of youth would choose to take his or her own life. It is this seeming lack of understanding and awareness by adults of the turbulence and stress experienced by adolescents which, for some, far outweighs the joy of life, that has been partly responsible for the current alienation of many young people (Klagsbrun, 1976). Adolescence is more than just the "in-between" stage as Konopka (1983) fears it is far too

often described. She denotes the many and significant "firsts" one goes through that combine to make adolescence a time of heightened vulnerability and pain. For some there seems to no way out but to end the pain by ending their lives. Suicide has become a widespread occurrence that neither adults nor young people can ignore or minimize the difficulties that contribute to it's cause.

The dramatic increase in the rate of reported suicides in youngsters to some extent parallels the increase in divorce rates and other indices of family disorganization and discord (Reynolds, 1987; Shaffer, 1973; and Toolan, 1974). Petzel & Riddle (1981), Garfinkel (1988), and Pfeffer (1988) make note of several important family factors associated with adolescent suicide including parent physical abuse, parental depression and suicidal behavior (Hendin, 1975), and parental alcoholism. While these events are in all probability related, there is no evidence of a direct causal link. Although no single cause can explain the upward trend in adolescent suicide, it is generally accepted that despite markedly ambivalent feelings about dying, the adolescent who attempts suicide concludes that it is the only solution after all other attempts to cope with his or her problem have failed (Grollman, 1971; Jacobs, 1971; Resnik, 1968; Shneidman, 1969; Berman, 1985; and Garfinkel, 1988). Whatever the many reason for the increase, the fact remains that there are many thousands of distressed and suicidal youngsters, most of who go unidentified until serious behavioral pathology occurs. The

staggering rate of adolescent suicide attempts and deaths indicate the need for an understanding of the assessment and formation of clinical judgments of the seriously suicidal adolescent.

Suicidal Behavior:

A hierarchical continuum of suicidal behavior is illustrated in Table 1 to clarify the variability of this disturbance (Reynolds, 1987; Glaser, 1964; and Pfeffer & Plutchik, 1982). Of particular note is the pseudo-suicide attempt coined "a cry for help" by Faberow and Shneidman (1961), which is commonly observed in adolescent suicide attempters. This label is used to describe suicide attempts which are of a minimally injurious nature or have a very low probability of success. Particularly in adolescents such suicide attempts are often viewed as a form of acting-out, manipulation, exercise of control, or attention-seeking behavior. An unfortunate result is that these suicidal behaviors are given minimal attention; the justification that attention would reinforce the behavior. This is a groundless perspective. All suicide attempts, as well as threats, should be considered indicators of significant psychological distress (Pfeffer, 1988). To minimize the importance of such behaviors may communicate to the adolescent that no one cares about his or her survival. It is important to note that nearly all adolescents who completed suicide attempts had made previous

Table 1

Continuum of Suicidal Cognitions and Behaviors (Reynolds, 1987)

IDEATION

- Morbid ideation, thoughts of death
- Wished never born, better if not alive
- Life not worth living
- Wishes were dead
- Others would realize worth if dead
- Suicide as retribution/punishment of others
- Thoughts of killing self (general)
- Thoughts of killing self (specific)/thoughts of ways how/thoughts of when and where

INTENT

- Writing notes and/or will
- Giving away possessions
- Subtle and/or overt threats
- Minor self-destructive acts

ATTEMPT

- Pseudo-suicide attempt (cry for help)
- Minor attempt (distinct possibility of failure)
- Major attempt (very small probability of failure)

COMPLETION

threats or attempts (Cohen et al., 1966; Robbins & Alessi, 1985; and Slaby & McGuire, 1987). Clearly each threat or attempt must be considered significant and attention must be given (Toolan, 1974).

Miller (1981) organizes suicidal behavior as intentional, marginally intentional, and accidental.

> Intentional suicidal behavior is associated with efforts at self-destruction which appear to be deliberate to others, although that may not be the adolescent's real intent. The behavior is usually preceded by more or less subtle warnings which may not be conscious. If the warnings are ignored, such failure at communication may well reinforce the likelihood of the act occurring.

Miller (1981) describes marginally intentional suicidal behavior as "usually chronic in nature and is typically seen in those individuals who neglect the self. Sometimes these individuals enact suicide while hoping that they will be found and saved." Accidental suicidal behavior may occur in (1) those social systems which reinforce adolescents' self-destructive behavior, and abuse of toxic drugs; (2) failure of adolescents to be aware of their own physical limitations; (3) and mentally ill adolescents who have no conscious intention to commit suicide but do so out of wish to reconciliate or fuse with another part of self, as in the case of some schizophrenic teen-agers (Miller, 1981).

It is the opinion of experts in the field of suicidology

that people who make suicide attempts are not one homogeneous group (Litman, 1970; Maris, 1981; Murphy, 1984; and Peck, 1986). The characteristics of suicidal adults differ from suicidal children (Smith, 1983; Pfeffer, Conti, Plutchik & Jarrett, 1979) and people making mild attempts have been found to be different from those making serious attempts (Farberow & Shneidman, 1961; Pallis, Barraclogh, Levey, Jenkins & Sainsbury, 1982; Slaby & McGuire, 1986; Robbins & Alessi, 1985; Reynolds, 1987; and Beck, Kovacs, & Weissman, 1975). Some people threaten or attempt suicide to get help, attention, or some desired interaction with their environment. These people want to live even if their terms are not met (Berman, 1985). There is another group of seriously suicidal people who make threats or attempts because they want to die even if their terms are met. This group is more lethal, more likely to successfully commit suicide.

According to the literature it seems there are at least two levels of lethality for suicidal behavior; that is, suicidal risk and imminent danger of death due to suicide (Rotherman, 1987). Rotherman (1987) differentiates these two levels of lethality stating that imminent danger of suicide is an evaluation of the youth's emotional state, with reference to specific situational contexts. She says suicide risk is a global term that can be used to select populations which may potentially become an imminent danger to self at some future time, but for whom over-predication is inevitable. While statisticians might facilitate

the selection of individuals or groups of youths who are suicide risks, clinical judgments form the basis of the evaluation of imminent danger to the self.

In most instances the suicidal act is not unpredictable; but neither is it inevitable (Grollman, 1971). As a final step in the long-term progression toward the social isolation characteristic of suicides (Jacobs, 1971), the act of suicide is unlikely to occur without warning. Once the suicidal adolescent is recognized, clinicians face the difficult dilemma of identifying who is at greatest risk for medically serious suicide attempts. Many more adolescents make nonlethal attempts than lethal attempts, and even more express suicidal thoughts. Presumably not all of these adolescents are at risk for potentially deadly attempts. The increasing rate of suicide among teens has elevated the need to evaluate the seriousness of suicide risk.

Evaluation of Suicide Potential

Measurement Scales:

Many scales have been developed to predict suicidal risk, 63 inventories in total (Farrell, 1988). Most scales were developed and normed for use with the adult suicidal population. These scales are not useful when used with adolescents because they are not designed with considerations of developmental stages of adolescence (Rotherman, 1987). For example, most scales discuss medical lethality which is used to evaluate suicidal risk in

adult populations (Pallis & Sainsbury, 1976). Medical lethality quite often is meaningless to teens since they just do not know the true dangerousness of much of what they use to attempt suicide. Similarly, adolescents who attempt suicide have been demonstrated to be poor problem solvers with little ability to predict the consequences of their actions (Trautman, 1984).

Although various scales have been developed, none has been widely adopted for clinical use primarily due to questions about validity, and the general inconvenience and unavailability of using formal scales (Motto, Heibron, & Juster, 1985). The problem of validity may be understood on the basis of well-known characteristics of suicide, specifically 1) the many unknown and uncontrollable variables that contribute to outcome, 2) the relative infrequency of completed suicide, even in a known high-risk population, 3) the limitations of using completed suicide as a validation criterion without considering the intervention efforts necessarily directed towards recognized high-risk patients, 4) the differences in critical stressors in various age, racial, gender, cultural, and situation specific subgroups, and 5) the need for investigations to use a large sample, a prospective design, and a long follow-up period to consider a wide range of variables and to obtain enough suicidal outcomes to examine them statistically (Motto et al., 1985).

The inherent dilemma in constructing a scale to estimate suicide risk lies in the fact that high-risk issues in an

individual (i.e. health) cannot be generalized to a large population, and high-risk issues in a large population (i.e. age) do not necessarily apply to a given individual. With a population of one, risk prediction based on clinical judgment can be individualized but validation is not possible. By estimating risk in a large number of subjects, the accuracy of individual risk estimates is reduced but validation becomes feasible (Motto et al., 1985). Clearly, a scale can only be a supplement to clinical judgment and should not, on its own, override contradicting information.

Beck, Resnick, & Lettieri (1974) point out the difference between clinical and demographic predictors of suicidal risk. Demographic predictors must necessarily ignore individual characteristics. Even the application of a number of demographic variables will not specify a person very accurately. Surely there is value in utilizing demographic predictors of suicide risk, for example when planning programs. By identifying a particular high risk group in the population, the program can be developed specifically to meet the needs of the high risk group. For example, a suicide prevention center may be located in the area of a city that has the highest suicide rates. Clinical prediction, which implies some kind of intuitive holistic judgment and the use of psychological data, focuses on individual characteristics, enabling much more accurate pin-pointing of those individuals who are suicide risks (Beck et al., 1974).