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Adolescent Depression and Suicide

Introduction

Depressive disorders are not new in the history of humankind. There are descriptions of affective disorders found among the early writings of the Egyptians, Greeks, Hebrews, and Chinese. In addition, there are similar descriptions found in the literary works of Shakespeare, Distoevski, Pie, and Hemmingway. The list of historical figures who have suffered from recurrent depression is a rather long and celebrated one an includes Moses, Rousseau, Dostevski, Queen Victoria, Lincoln, Tchaikovesky, and Freud.

"Why live? Why die? To keep on living an empty life takes patience from an empty person..."
As cited in Mccoy's (1994) book, Understanding your Teenager's Depression, these words were taken from the diary of Vivienne Loomis, a bright, attractive, well-loved fourteen-year-old whose suicide in 1973 shocked and bewildered both family and friends. However, Vivienne Loomis did give warning signs; she had written letters to her teachers. Tragically, her signals were not taken seriously. Her teachers thought that because she was so bright and capable and had so much to live for that she just couldn't be truly serious about taking her own life. Sadly, they were wrong.

Until the last two decades, the mental health professions, dominated by traditional psychoanalytic theories, held the erroneous belief that serious, chronic depression could simply not exist before the formation of the idealized self-image (also called the superego), a developmental stage that is generally not reached well into adolescence. That is, a youngster's personality was not deemed sufficiently mature to suffer a serious depression. Unfortunately, this belief resulted in the delay of much needed research into the phenomenon of childhood and adolescent depression. But now we are now finally waking up to the reality and seriousness of teenage depression and, as a result, more and more professionals are recognizing the fact that young people can and often do become seriously depressed.

Epidemiology

Population studies of adolescents have reported prevalence rates of between 0.4% and 8.3% for depression. The lifetime prevalence rate of major depressive disorder (MDD) in adolescents has been estimated to range from 15% to 20%, which is comparable to the lifetime rate found in the adult population, suggesting that depression in adults often begins in adolescence. In other words, by the age of 18, approximately 20 percent of all teenagers have had at least one episode of clinical depression, yet up to 85 percent of clinically depressed adolescents are unidentified and untreated. In children, MDD occurs at approximately the same rate in boys and girls, whereas in adolescents, the

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female-to-male ratio is approximately 2:1, paralleling the ration reported in adult MDD. While the nature of this sex difference is as yet unclear, it has been attributed to genetics, increased prevalence of anxiety disorders in families, biological changes associated with puberty, cognitive predisposition, and socio-cultural factors.

What is Depression?

Depression is often used a sort of catchall phrase to describe a variety of symptoms. Sigmund Freud conceptualized depression as a reaction to early losses and separations which results in rage and guilt turned inward. Today one might describe depression as the result of a complex mix of social, psychological and/or physical factors that can act on the person's nervous system, triggering sadness, hopelessness, and self-deprecating thinking and behavior. For some adolescents, depression comes in the wake of major loss or setback and for others the reasons are not so clear-cut.

Adolescent depression is clearly more than a signal symptom of "sadness." It is a "syndrome" that is comprised of a multitude of symptoms that reliably co-occur. These symptoms can be divided into the same major categories of symptoms used to describe depressed adults, including affective, cognitive, motivational, physical, and vegetative. In addition to the more classical symptoms of depression, adolescent depression is often typified by increased anger, running away, social withdrawal, diminished school performance, agitation, and feeling unloved.

There are a variety of different types of depression which vary considerably in severity, duration, and impact on the adolescent's life.

There are three types of clinical depression which must meet very specific diagnostic criteria established by the American Psychiatric Association and are published in the DSM-IV, the diagnostic guide used by physicians, psychologists, and other mental health professionals. Clinical depression differs from depressed mood in severity and variety of symptoms, which include physical problems such as fatigue, sleep and appetite difficulties, and psychomotor problems.

Adjustment Disorder with Depressed Mood (nonclinical): These feelings of sadness and unhappiness occur as the result of a specific event in the teenager's life. It can be triggered by a set-back such as failing to make a sports team or to win an academic award or to the loss of a girlfriend or boyfriend.

Dysthymic Disorder: This is a form of chronic depression that is diagnosed only when a teenager has experienced depressed or irritable moods consistently over a period of one year or more without more than two months at a time without symptoms. Associated symptoms include appetite disturbances, sleeping too much or not enough, low energy level, low self-esteem, impaired decision-making ability, and feelings of hopelessness.

Major Depressive Disorder: In order to have MDD, the adolescent much have experienced five or more of the following symptoms during a two-week period which represents a change from a previous level of functioning and at least one of the symptoms much be either depressed mood or loss of interest or pleasure.

- Depression or irritability most of the day, nearly every day.
- Loss of or diminished interest in activities he or she may have enjoyed previously.
- Significant weight loss or gain, diminished or increased appetite, In teens, the failure to make expected weight gains as the body grows can be an important sign of trouble.
- Feelings of restlessness or being slowed down.
- Daily fatigue or loss of energy
- Sleep disturbances - either sleeping too much or too little.
- Feelings of worthlessness or excessive or inappropriate guilt on a daily basis.
- Suicidal thoughts, plans and/or attempts.

Bipolar Disorder: In this disorder moods alternate between manic, or abnormally elevated, moods - marked by agitation, decreased need for sleep, inflated self-esteem, incessant talking, flight of ideas or racing thoughts, increased activity level, and excessive involvement in pleasurable but sometimes risky activities and depression.

Note to teachers: Teachers, in particular, are often the first to recognize that something is not right with one of their students. It is important that the teacher be able to recognize possible warning signs for depressions. Please refer to page 16 for a list of possible manifestations of depression in the classroom.

Why Adolescent Depression?

Adolescent depression is alive and well and is now considered to be the number one mental health problem afflicting the adolescent population. Although adolescents have always been prone to depression for a variety of reasons to include loss, change, and parental depression, today's teens face added challenges in that they are growing up in world that is quite different from their parents' youth.

- While parents of today's teens came of age in a era of economic growth and optimism, today's teens have come of age at a time of declining national power, of corporate downsizing, and when more and more families are plagued with unemployment.
- College costs are soaring and a college degree is no longer a guaranteed ticket to the "good life".

- There has been an erosion of family earnings. Between 1979 and 1990, according to the Center for the Study of Social Policy, the real median income of families with children fell by 5 percent.
- To keep families afloat financially, more mothers are working outside the home: 61 percent in 1990 versus 53 percent in 1980.
- Approximately 40 percent of adolescents will grow up in homes affected by parental divorce.
- Today's teens face additional stresses in the school environment as well, with resources dwindling and campus violence and harassment increasing.
- Today's teens are barraged with music that promotes violence, rebellion from authority, suicide, live for the moment, cruelty, and even Satanism.
- Our society has moved toward rejecting spiritual values as anything of importance and, resultantly, many teen grow up in families who are lacking in their ability to instill strong values. Moreover, parents have moved toward an attitude of increasing permissiveness which results in children who are self-centered and live by a mentality of entitlement rather than of giving. This attitude only leads to emptiness and disillusionment rather than fulfillment.

According to Dr. Kathleen McCoy (1994), today's adolescent youth face more dangers than ever before, and these risks to health and to life can be exacerbated by depression.

- Drug use is on the rise among teens as young as thirteen, according to the 1993 National High School Senior Survey on Drug Abuse. In a poll of 50,000 students, 26 percent of eight-graders used alcohol on a regular basis. By the senior years of high school, this figure raised to 51 percent. Alcohol and marijuana, which are often used to assuage depression, actually reduce seretonan levels, a neurotransmitter which has been linked to depression.
- Teen suicide, a topic to be covered later in this paper, continues to rise.
- The majority of teenagers are sexually active during their high school years and although they are physically capable to engage in sexual activity, most are not psychologically ready.
- Eight million young people each year are infected with a sexually transmitted disease: Every thirty seconds, another teenager acquires a sexually transmitted disease.
- More than one million teens -- most under the age of sixteen -- run away from home every year. These runaways are considered to be especially high risk for AIDS infection.
- Gay and lesbian youth have a two- to threefold risk of suicide and are at a much higher risk for depression.
- Girls have much more difficulty with depression in adolescence, according to many studies.

Precipitants of Depression

As we can see from the above, teenagers are certainly vulnerable to depression because of the state of the world they are forced to live in. Listed below are some of the precipitants of depression which can catapult the adolescent into a depressive crisis.

Significant losses: The loss can be due to a death, parental divorce, separation, or the loss of an important friend or romantic attachment. Or the loss might be more symbolic such as the loss of childhood, of a familiar way of being, of aspired but unattained goals, or the loss of innocence

Negative Cognitive Style: It is commonly accepted that depressed individuals develop a cognitive style which involves a negative perception of the past, present, and future. Events which might be construed as basically neutral or good are distorted in the depressed individual's mind to be negative. This negative thinking actually brings about negative or depressed affect which can precipitate or worsen a depression. Please see page 17.

Drug and alcohol use: As we all know, alcohol is a chemical depressant and in many cases is actually like taking a pill that encourages depression. Not only does it lower serotonin, it also kills brain and liver cells. After about six months of age, the body is no longer forming the types of brain cells that are involved in the thinking process, so it is vital that one takes care of the brain cells he has. It has been demonstrated that only one shot of whiskey can kill up to 2,000 brain cells which can never be regenerated. Marijuana, which is the second drug of choice among adolescents, also lowers serotonin levels.

Hypothyroidism: In this disorder, the thyroid gland fails to make enough of the hormones it is supposed to make which can lead to severe depression deep enough to invite suicidal tendencies.

Infectious mononucleosis: This and certain other physical illnesses or physical trauma can cause serotonin depletion and lead to depression.

Too much stress: When the body is under too much stress, it becomes vulnerable to a multiplicity of illnesses to include depression. Moreover, stress has been associated with serotonin depletion.

Unresolved bitterness, guilt, shame, vengeful motive, and stuffed anger: Dr. Paul Meirer (1996) has stated that over 90% of the adolescents which have been treated at the Minirth-Meier New Life Clinics are caused by holding grudges. He postulated that the holding grudges, whether petty or major, depletes serotonin which precipitates depression.

Inactivity: Inactivity can contribute to depression and depression fuels inactivity. Physical activity, especially vigorous physical activity, makes an important contribution toward maintaining a healthy neurotransmitter balance in the brain.

Course

The average length of an episode of major depression in adolescents is seven and a half months and the average length for Dysthymic Disorder is three years. In terms of recovery rates, Kovacs et al (1984) found that approximately 92% of adolescents with major depression recovered within a year and a half. On the other hand, 89% of adolescents with dysthymic disorder recovered after 6 and a half years. In both cases, the younger the age of first onset, the longer the period of recovery. In addition, adolescents with either disorder were at greater risk for a later episode. Adolescents who had major depression stood a 72% chance of another episode within 5 years. Moreover, the periods of normality between episodes were found to be relatively short; not in excess of two years.

Treatment of Adolescent Depression

Effective treatment of adolescent depression is best delivered through a multimodal treatment approach. That is, it must involve approaching the problem from several different but integrated vantage points.

Psychotherapy: Effective psychotherapy must help the adolescent deal with resolution of significant losses, both real and symbolic. Working through anger issues, restoring balance in life to include minimizing stress and anxiety, resolving family relationship difficulties, restoring good sleep hygiene, eating, and sleeping habits, and improving assertiveness and self-esteem are all potential goals of treatment which need to be considered.

The negative cognitive thinking previously discussed should always be a key component of treatment. Cognitive restructuring procedures are designed to modify the depressed adolescent's thinking and the premises, assumptions, and attitudes underlying the adolescent's thoughts. They are designed to change the way the adolescent derives meaning from the world (Meichenbaum, 1977). Please see page 18 for a list of common cognitive distortions that can cause or exacerbate depression.

Beck's (1979) approach seems to be the most adaptable to adolescents and involves four techniques: (1) What is the evidence of the illogical belief? (2) What are alternative ways of looking at it? (3) What if? This is used when the situation is such that the adolescent is faced with "real" difficulties but must learn to put them into prospective and develop a plan to deal with his reality. (4) Behavioral assignments.

Communication patterns in the family: Parents should be helped to become aware of common communication patterns that can become especially problematic for adolescents.

- Labeling and belittling - "You're just a lazy spoiled brat!" This approach only serves to harm self-esteem and destroy the adolescent's desire to change.
- Ordering , prescribing, and lecturing - When the adolescent hears her parent winding up for another lecture or prescription, she is likely to tune her parent out.
- Taking over the problem - It is essential that one determine who owns the problem before jumping into it. Too often parents take charge and dictate to the adolescent what "they" think should be done. It is vital that parents listen, recognize that it is most likely the teenager's problem. In doing so, the parent is able to stay more objective and not take the teen's problems personally in order to be in a position to act as a caring consultant rather than a dictator.
- Giving mixed messages - We don't always say what me mean which results in confusion, misunderstandings, and blocked communication. For example, a parent might say something positive which his soured by mixed messages such as "That's nice, but don't get a big head about it" or "Oh fantastic! Wait until I tell my friends." These messages convey that the acceptance of the child is conditional or the success is not the adolescent's but is the adult's or that excellence is expected. Another type of mixed message is saying "yes" when you really mean "no." For example instead of telling a teen that he can't go swimming in the lake with his friends, the parent says yes you can go because all of your friends are going but I will worry about you all day long; but have a good time. This puts the teen in a no-win situation. If he goes, he feels guilty, if he says home, which is what the parent really wants, he feels angry and deprived.
- Dishonesty: A parent might promise a child that he will grow even though he is well into puberty and the promised event never happens. A parent might over praise the academic accomplishments of her learning disabled child when she knows that he is not doing well in school. A parent might say nothing is wrong when he is really angry at his daughter. Such messages confuse the teen and make her feel as though she cannot trust the parent and may cause her to discount the parent's point of view altogether.
- Interrogation - Asking too many questions can create distance and block healthy communication. The natural tendency of a teen is to close up when he feels he is being pushed too hard for information. It is more productive to create an atmosphere of openness and warmth to keep questions to a well-thought-out minimum.
- Minimizing the situation - Too often an adolescent's problems seem trivial to an adult's perspective. For example, a teen I saw in therapy became clinically depressed when his pet rat died. It was a challenge for me to take the loss seriously but it had to be done in order to avoid short-circuiting our relationship. Many parents have shut

down the communication process with their teens by saying things such as "don't worry, you'll get over him" or "you shouldn't be feeling so down, you have a wonderful life."

The Role of the Teacher: Although teachers should not take a therapeutic role in helping adolescents with depression, they are often the first to recognize that one of their students is depressed. It is essential that teachers have access to mental health staff so that their concerns about a student can be discussed and the appropriateness of a referral can be addressed. This is essential because the responsibility to determine the necessity of a referral should not rest solely on the shoulders of the educator but rather should be a team decision. The teacher should not ask the student's permission if (s)he can talk with the school psychologist but should inform the student of her decision of discussing the matter with a mental health professional. Teachers should never underestimate the importance of a demonstration of caring such as a short talk or a reassuring touch.

Special Education: It is important that educators appreciate that according to federal regulations as defined in PL 94-142, a depressed adolescent can qualify for special education services if the depression adversely impacts on educational functioning, is to a "marked degree" (i.e., severe), and has existed over a long period of time (i.e., chronic). In taking this step, it is essential that one is sensitive to how the adolescent will perceive the move. Since depressed individuals already have a negative view of themselves, such a move could confirm in their own minds that they are deficient. It is also important that special education placement does not foster over-dependency on the resource teacher for academic and emotional support. Although this may be appropriate at first, the programming must have built into it steps that will lead to independence. Finally, care must be taken to ensure that the programming does not isolate the child and foster social withdrawal.

Medication: Although there is some controversy about the actual effectiveness of antidepressant medication in the adolescent population, medication should be considered when the depression is severe or when suicidal ideation is of concern. Two classes of antidepressant therapy are most commonly used. It is important to note that it usually takes up to four to five weeks before any significant effect of the medication is appreciable.

Tricyclic Antidepressants (TCA's) (e.g., imipramine): An older class of medication, TCAs continue to be prescribed for adolescent depression. It is important to note that all of the controlled double-blind trials, with the exception of one study, have reported no significant differences between placebo and TCAs in adolescents as well as in children. However, in fairness, it must be understood that many of these studies are fraught with several methodological problems. Possible side effects are drowsiness, dry mouth, constipation, blurred vision, confusion (rare), psychotic reaction or mania (rare),

lowering of seizure threshold in children with seizures or abnormal EEG, heart problems, and hypertension or skin rash (rare). Overdoses of this medication can be lethal.

Selective Serotonin Reuptake Inhibitors (SSRIs) (e.g., fluoxetine/Prozac): The reports that SSRIs have been efficacious for the treatment of adults with MDD, together with the fact that SSRIs have a relatively benign side effect profile, low lethality after an overdose, and easy administration, have facilitated the use of SSRIs in children and adolescents. In fact, from 1989 to 1994, the prescriptions for these populations by physicians has increased fourfold. Open studies have reported a 70% to 90% response to fluoxetine for the treatment of adolescents with MDD. However, a double-blind, placebo controlled study with a very small sample size did not reveal any significant effect. On the other hand, a large double-blind, controlled study underway has revealed preliminary positive results (Emslie et al., in press). The most common side effects of the SSRIs are agitation, restlessness, and gastrointestinal symptoms. More troublesome but uncommon side effects include weight loss, nausea, and insomnia.

Adolescent Suicide

A 15 year-old girl was asked by her therapist how she made sense of a particularly dangerous behavior in which she was engaged and responded, "Gee Doc, don't you know? I live in the suicide generation!" Although this statement was offered jokingly, it obviously spoke volumes about he significance of adolescent depression and suicide in our time. Has this notion of self-destructive behavior so permeated the fabric of the lives of adolescents that many of them see themselves as destined to self-destruct as a generation?

- Suicide is the second leading cause of death among the adolescent population. Although the suicide rates for other age groups have remained relatively constant, the rate for the 15 to 24 year-olds has more than tripled over the past 30 years and has quadrupled for adolescents between the ages of 15 and 19 during this time.
- In 1990 an estimated one million U.S. high school students attempted suicide, and approximately 3.6 million students in grades nine through twelve (30% of all students in that range) reported thinking of suicide during that year.
- The National Adolescent Health Survey in 1998 revealed that of the 11,000 teenagers polled, 25% of the males and 42 percent of the females said that they had given serious thought to suicide at some time in the past.
- About 5,000 young Americans between the ages of 15 and 24 successfully commit suicide each year.
- The Gallup Organization's National Teen Suicide Audit revealed that 60% of teenagers personally know other teens who have attempted suicide. Fifteen percent of those surveyed had considered suicide themselves.
- Six percent of American teenagers have attempted suicide.

Mental Illness:

- Research has shown that depressive syndromes, including major depression, dysthymia, adjustment disorder with depressed mood, and bipolar disorder frequently characterize adolescent suicide victims. However, although the majority of adolescent suicide victims have exhibited symptoms of depression, it should not be assumed that most depressed adolescents are suicidal.
- Suicidal adolescents may be hostile, impulsive, or delusional. Sometimes a suicidal act is a way of saying "You'll be sorry" for the teen who is angry at parents or peers and who acts on impulse without considering that suicide is a permanent solution to a temporary problem.
- Some teens delude themselves into thinking that death really is not permanent. Dr. J. Kronenberg and his colleagues at the Shalvata Mental Health Center in Israel have identified the "Sleeping Beauty Delusion" as a particularly ominous suicide risk in adolescent girls, in particular. It is believed that these adolescents display a common

thought disorder that they might die by suicide now to be awakened or reborn via a kiss from a future "prince charming." They fantasize about awakening in a better world.

Substance Abuse:

- Adolescent substance abusers are three times more likely than controls to commit suicide and to use more lethal suicide methods.
- A study at the University of Pittsburgh found that teens who commit suicide these days are ten times more likely to be drunk or high on drugs compared to their counterparts twenty years ago. And if intoxicated, the teens are seven times more likely to use more effective means - such as guns - and to succeed in their suicide attempt.
- The substance most commonly associated with adolescent suicide is alcohol.
- In a recent study, it was found that the main psychiatric diagnosis for 53 percent of 133 consecutive youth suicides in the San Diego area was substance abuse.
- Dallas psychiatrist, Dr. Frank Crumley, who has treated and studied a number of suicidal teenagers, has noted that the most typical suicide candidate is a severely depressed, impulsive girl with a history of drug abuse.

Conduct Disorder: Another major area of pathology among adolescent suicides is conduct disorder. In fact, some studies have suggested that conduct disorder is associated with a greater suicide potential than major depressive disorders. A history of aggression and antisocial behavior is often associated with conduct disorders in adolescent suicides.

Family Environment:

- Significantly high levels of family conflict, including violence and suicidal tendencies, are often found in adolescent victims.
- Suicidal adolescents report their families to be less pleasant and indicate more negative perceptions of their parents.
- Family relationships among suicidal teens are reported as less affectionate than the families of nonsuicidal adolescents.
- Often, there is a "symbiotic relationship" between parent and teen that allows for no autonomy.
- Parents are often extremely lenient or authoritarian and may move often, which prevents the teen from establishing stable ties outside the family.
- Familial risk factors for suicide include generalized mental disorders, depression, substance abuse, and aggression toward and abuse and neglect of the children.
- Studies have revealed that families who are isolated, especially within an inflexible family system, are more prone toward adolescent suicide.
- Suicidal behavior of another family member is a very significant risk factor for adolescent suicide.

- It has been estimated that as many as 50% of adolescents who attempt suicide had a family member who committed suicide.

Sociocultural Factors: There are a number important factors which are seen to contribute to adolescent suicide which do not fit easily into the aforementioned categories.

- A significant number adolescent suicide victims are involved in a disciplinary confrontation shortly before their death, mostly likely because they are fearful of the consequences.
- The potential role of stressful life events has also been identified as a risk factor. One study revealed that high school students who had reported suicide attempts or for whom there were assumed attempts in the previous year had stress scores 33% higher than nonsuicidal students.
- Another important sociocultural phenomenon of particular relevance to teenage suicide is the matter of suicide imitation or the "copycat" dynamic. Exposure to suicide within the family or social network of adolescent suicide victims is more common than for controls. However, it is important to note that exposure to anther's suicide probably is best considered an accelerating risk factor for those already predisposed. Probably the single most predictive factor of the risk for suicide in adolescents is a history of prior suicide attempts.
- It has been noted that prior suicide attempts, threats, ideation, or some combination of these are the most significant predictors of risk for suicide in adolescence.
- The teenager is often isolated without a network of supportive relationships. In a five-year study of suicidal adolescents, Dr. Hendin noted that most had little emotional connection to others. He observed that those in college often tended to use schoolwork to withdraw from others. Whereas most of the college-age students were unhappy with their lives but were afraid to change, suicidal high school students engaged in a lot of provocative behavior. Finally, teens who are isolated from peers by family responsibilities and whose emotional connections are limited are especially at risk for suicide.

The Major Warning Signs of Suicide

- Severe depression or a sudden improvement in mood after a severe depression.
- A substance-abuse problem, especially if it is coupled with depression and feelings of hopelessness.
- Expressing feelings of hopelessness, helplessness and unhappiness and a general sense of futility.
- Giving away prized possessions.
- Withdrawing not only form family but also from friends.

- Talking about suicide or death as a release.
- Discussing methods of suicide or specific plans for a possible attempt on her own life.
- Previous suicide attempts.
- The teen knows someone who has committed suicide. One study revealed that over 50% of teens who attempt suicide have a close relative who has attempted suicide.

Myths about Suicide

People who talk about suicide don't commit suicide: Many people ignore or dismiss suicidal behavior as a means of getting attention. But the fact is that eight of ten people who commit suicide give definite warning signs of their intentions.

Suicide happens without warning: Most often, suicide is the result of a deep, internal struggle which has built up over time. While suicide sometimes seems impulsive, this is not usually the case. As previously mentioned, warning signs are almost always presented, but people are unwilling or unable to recognize or acknowledge them.

Once a person decides to kill him or herself, there is nothing that can be done to stop them: Most suicides can be stopped. Very few of those who attempt suicide truly want to die. Rather, they experience strong ambivalence toward the self-destructive act: torn between wanting to live and wanting to die. Though the suicidal teen really wants to live, she also wants to terminate the perceived intolerable suffering. Says one leading authority, "The leap off the building may be the tragic result of a 49 to 51 internal vote."

Adolescents who commit suicide always leave suicide notes: Not true. In actuality, only 15 percent of completed suicides leave notes.

Most suicides occur late at night: Not true. Although there is considerable variation in the placement of the exact time frame among suicidologists, they are in general agreement that suicides are most likely to occur when the chance of discovery is the greatest.

Talking about suicide to a troubled person will give that person morbid or dangerous ideas: If the "suicidal" teen is sincere about wanting to die, those thoughts already exist. On the other hand, talking will often help the person acknowledge and work through his or her suicidal ideas. It has been said that talking about suicide will not cause suicide, but failing to talk about it can have disastrous consequences. Most people who attempt to commit suicide are relieved to talk about what has been troubling and compelling them if given the opportunity.

The secret lies in getting someone over the "hump" . If you can just pull someone out of a depression, they won't kill themselves: Puzzelingly, the movement out of a depressed state may represent the most dangerous time. While it is true that well over half of the successfully completed suicides occur during a depressive episode, a considerable number of adolescents who attempt suicide do so within 90 days of the first attempt; when they appear to be recovering. Many professionals believe that severely depressed persons with suicidal tendencies may lack the will or physical energy to carry out the self-destructive act. With improvement, however, the energy to follow through with the suicide may again be present.

Crisis Management of the Suicidal Adolescent

Availability: The therapist's availability is of primary importance for the suicidal teen. The adolescent should be given reassurance of the therapist's availability with specific directions and information on how to access the therapist. Teachers and school counselors should also be more available and more open to just talking and making contact with the adolescent. Note, this does not imply that the teacher should take a therapeutic role but rather to merely be warm, caring, and supportive.

No-Suicide Contract: It is prudent of the therapist to enter into a contractual agreement with the adolescent that suicide attempts will not be made within a specified period of time. Additionally, the teen should agree that he will contact the therapist, his parents, or another responsible adult should he begin to feel strongly suicidal.

Reassurance: The basic message of suicide's irreversibility - the fact that most crises eventually pass and that nothing is lost by postponing the consideration of suicide while the therapist works with the client to solve the relevant problems - should be stressed.

Problem-Solving Training: Suicidal teens who feel overwhelmed and hopeless in dealing with their problems often can be helped through systematic problem-solving instruction. She needs to learn how to isolate one problem at time from the several weighing on her and how to develop problems-solving strategies to address each specific problem.

A Support Network: It is crucial that the adolescent have a strong support network of caring family and friends.

Removal of Possible Means of Suicide: The therapist should inquire directly about the availability of firearms, other weapons, and potentially fatal drugs in the teen's environment. Lethal means should be removed from the home.

Hospitalization: When other interventions are not possible or sufficient, hospitalization of the suicidal adolescent should be seriously considered. It is important to carefully weigh the advantages and disadvantages of this decision.

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* Portions of this paper were adapted from the above references and were not individually referenced.