DOCUMENT RESUME

ED 036 854 CG 005 109

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TITLE The School Guidance Counselor As A Preventive Agent to Self-Destructive Behavior.
INSTITUTION National Inst. of Mental Health (DHEW), Bethesda, Md. Center for Studies of Suicide Prevention.
PUB DATE [70]
NOTE 11p.

EDRS PRICE EDRS Price MF-$0.25 HC-$0.65
DESCRIPTORS *Behavior Problems, *Counselor Functions, *Counselor Role, *Psychopathology, Pupil Personnel Services, Students, *Suicide

ABSTRACT

The report deals with the growing problem of self-destructive behavior among the younger age group and points out the importance of the counselor's role toward a disturbed youngster who spends a major part of the day in school. Defined are three types of acting-out behavior: (1) self-assaultive behavior, (2) self-destructive behavior, and (3) suicidal behavior. The author suggests that the counselor establish the image of a friend to communicate with the student. Two kinds of mental disorders which are often associated with suicide are described: (1) depressive states (manic-depressive psychoses, involutional melancholia, paranoid states, psychotic depressive reactions, depressive neurosis); and (2) schizophrenic reactions (paranoid, schizoaffective, catatonic). The author compares the behavior of an adult to that of a child. Also listed are symptoms of the potentially self-destructive youth and the type of assistance the counselor might offer. (Author/MC)

THE SCHOOL GUIDANCE COUNSELOR AS A PREVENTIVE AGENT TO SELF-DESTRUCTIVE BEHAVIOR

by

Calvin J. Frederick, Ph.D.

The problem of self-destructive behavior among younger age groups is becoming a problem of major concern and is receiving renewed attention from the Center for Studies of Suicide Prevention at the National Institute of Mental Health. Such disturbances create ever-increasing problems for school and college personnel as well. Until quite recently it was generally thought, even by many professionals, that youngsters below the age of 15 years rarely engaged in serious self-destructive behavior to the point of taking their own lives. As more and more evidence comes to the fore, it is clear that youngsters act out their frustrations in a multitude of ways, some of which are self-destructive.

Three terms are often used to describe behavior of this type. One is self-assaultive behavior which connotes an attack or an assault upon one's self that may or may not be suicidal. It is actually not uncommon for children to threaten injury to themselves as well as to others and, in some instances, carry it out. They may actually verbalize the fact by warning the parent or some parental surrogate that they are going to hurt themselves. It is frequently done by saying, in effect, "I'll punish myself before you can punish me." thus disarming the parent or the authority figure by conveying the message that "You can't do any more

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to me than I have already done to myself; hence, your punishment is a waste of time." In other instances, the youngsters will injure themselves and become "accident-prone" in order to gain sympathy and love which they feel is not forthcoming in other ways. Usually this stems either from sibling rivalry in an effort to draw attention away from the rival at any cost or from past situations which have led the youngster to believe that it is the most effective way of getting real love and affection from the parent.

The term self-destructive behavior applies to more serious cases than most behavior labeled self-assaultive. Although here too there are varying degrees of intensity, self-destructive, by definition, ultimately becomes synonymous with suicidal behavior. However, there are "psychological equivalents" of self-destruction which need to be recognized since they are often unconscious on the part of the individual committing such acts. An example of this kind of behavior can be found in youngster who has some physical infirmity such as diabetes and fails to take insulin properly. There are varying degrees of understanding by the youngster regarding ideas of death, even among teenagers. It is not unusual for an obese girl who is diabetic to fail to take her insulin and go into a serious state of shock approaching fatality and in some instances eventuates in her demise. Despite an intellectualized understanding beforehand that she will go into shock and seriously endanger her life, some of these girls have immature and romanticized notions of death. They believe that they will somehow be saved at the last moment even though they have acted upon the situation in such a manner that this is not likely. In other cases, they believe they will live in another

after-world in some manner which therefore precludes the behavior from being really suicidal in their own minds.

There is very real doubt about the age at which youngsters really understand the concept of death, particularly suicidal death. The youngest instance in the author's experience is that of a five-year old who was extremely bright and after thorough examination of the youngster himself as well as his parents, it was apparent that he did understand the notion of self-destruction and was engaging in genuine suicidal attempts. Ordinarily, youngsters of that age are not thought to have a grasp of such concepts but it is possible that a small percentage do. The age at which youngsters seem to understand the nature of their actions in self-destructive behavior will vary with their cultural background, relationship to their parents, presence of older siblings who engage in self-destructive behavior, intelligence, and exposure to violence in and outside of the home.

There has been a sharp increase in committed suicides in the age group of 15-24 yours over approximately the last decade. Although the suicide rate for males is 2 or 3 times that of females, the rate among non-white females has risen 183% during that time. Among all the younger age groups, the rise has been greater among females than males and greater for non-whites than whites.

Suicidal behavior can be regarded as more unequivocal than the other two types. It is the intentioned cessation of human life. Some authors like Shneidman (Shneidman, 1968) included subintentioned groups as well Being self-assaultive or self-destructive is not as far out on the continuum towards death as suicidal behavior. One can injure or destroy a

part of oneself without actually taking one's life, of course. There is a finality to suicidal behavior which sets it apart from the others, even though the difference is only a matter of degree.

The "Gate-Keeper" or Preventive Role for the Guidance Counselor

Youngsters who are genuinely suicidal usually do not consult directly with a family physician or a clinical psychologist. In the instance of youngsters, they are not likely to consult with parents, clergymen or anyone else whom they do not trust. They are more likely to consult with a peer and, thus, may not obtain the necessary support and guidance they need. If the school guidance counselor can establish the image of a stable and trustworthy friend, then he or she can easily become one to whom a troubled youngster can turn in time of serious need. It is in this role of true friend and counselor, that the schdprofessional in this field can render a unique, unmistakably gratifying and life-saving service to young people today. In order to help promote this role, the various signs of serious mental disorder and psychological first-aid principles will be outlined here.

Signs of Mental Disorder

Traditionally, there are two mental disorders which are often associated with suicidal acts. These are depressive states and schizophrenic reactions. In the context of self-destructive actions, some descriptive mention of each is worthwhile.

Depressive States

With adults particularly, there are various kinds of depressive states which can result in irrational behavior and serious consequences

even though the depressive period may be temporary. There is a good deal of question in the thinking of most experts as to whether or not childhood disorders such as schizophrenic reactions and various depressive states constitute the same entity for both youngsters and adults. It is generally believed today that there is a negative correlation in causality with respect to these mental conditions and self-destructive behavior when comparing young persons and adults. While most youngsters appear to be depressed in the sense that they are down-cast and low in mood, one would hesitate to put them into one of the classical depressive states nosologically. Seiden (Seiden, 1969) points out that if depression is defined as a syndrome where there are feelings of pessimism, worthlessness and guilt, then these symptoms would be more likely to characterize adult suicides than those of youngsters. It is also of interest that many adult suicides are missed even by physicians, most of whom are not alert to the symptoms, since this body of knowledge has not been taught in medical schools because of the relatively recent appearance of the entire crisis intervention field.

Only about one-third of the individuals who have committed suicide were diagnosed as falling into one of the traditional depressive states. These states for adults are: manic-depressive psychoses, which is marked by severe mood swings and the tendency to remission and recurrence frequently without any precipitating event; involutional melancholia where worry, anxiety and severe insomnia often accompany changes in middle life; paranoid states where mood and thought disorders are the central abnormalities without the presence of schizophrenia; psychotic depressive reactions where no history of mood swings is present but a

severely debilitating depressive mood is attributable to some stressful experience; and depressive neurosis which is manifested by an excessive reaction of depression because of internal conflict or because of some identifiable event such as the loss of a loved object or cherished possession. It is difficult to place youngsters into these usual adult categories, simply because their personalities have not formed completely into a cardinal type.

Schizophrenic Reactions

When schizophrenia is operating, the depressive behavior and lowered mood is also accompanied by disorders of thinking which are rather bizarre. In addition, the behavior is likely to show regressive symptoms to a more childlike for along with some withdrawal and isolation. Schizophrenic reactions which are most likely to result in self-destructive behavior are: schizophrenia, paranoid type, where the individual tends to blame other people and shows a good deal of hostility and hallucinatory behavior which may be turned upon himself; schizophrenia, schizoaffective type, where there are tymptoms with marked elation or depression accompanied by disordered and bizarre thinking; and schizophrenia, catatonic type, which is characterized by excessive and occasionally violent motor activity and excitement and/or by inhibition shown in stuporous behavior, mutism, negativism, and deterioration into a more childlike vegetative state (Diagnostic and Statistical Manual of Mental Disorders, 1968).

In schizophrenia as with depressive states, there is a marked difference between youngsters and adults. Very few adults who take their lives are diagnosed as schizophrenic, whereas a sizeable number of young-

sters who have taken their lives have apparently experienced some kind of schizophrenic reaction including hallucinatory behavior.

Because of their lack of maturity, suicidal behavior among children frequently reveals that they tend to imitate the behavior of loved ones who have died. This is especially true if the family member himself has committed suicide, such as a parent, older sibling or a favorite uncle or aunt. Death seems to represent the chance for reunion with the lost one. Parents who reject children and in effect wish them dead or out of the way can precipitate self-destructive behavior in these children. This author is convinced that severe punishment and child-abuse is likely to evoke violent behavior on the part of the recipient later, including suicidal behavior.

Symptoms to Look for in Potentially Self-Destructive Youth

The following list of behavioral clues should prove helpful to guidance counselors in their work with youngsters.

1. Adolescents contemplating suicide are not apt to communicate verbally with their parents at all. This, in fact, is part of the problem. They would be more likely to communicate with a peer or another interested individual in whom they have some faith and trust. Thus, if the youngster says he cannot talk to his parents, the listener should be alert to the nuances of serious problems.

2. Behaviorally, they are more likely to give signs which are a cause for concern. They may give away a prized possession with the comment that he or she will not be needing it any longer.

3. The individual is apt to be more morose and isolated than usual.

4. While insomnia, worry and anorexia often appear, the youngster may not have all the classical signs of a depression. It is a mistake to feel that an individual will not take his life unless he is clinically depressed.

5. Young males are likely to have experienced the loss of a father either through death or divorce prior to entering college, usually before the age of 16 years.

6. The father of young males is likely to be very successful and heavily involved in his profession or business without having had sufficient time to develop a father-son relationship which is solid.

7. Young males coming from a higher socio-economic class are likely to have spent some time during the period of secondary education at a private boarding school.

8. Girls who attempt suicide are likely to have had much difficulty with their mothers especially when there is a weak and ineffectual father in the home. The girl often turns to a boy friend for support and he in turn lets her down because he is not capable of satisfying her psychological demands. Frequently, the girl may believe she is pregnant.

9. Adolescents are apt to smoke heavily, suggesting the severe tension they are experiencing.

10. General efficiency and school work usually drops off.

11. Recently involvement with various kinds of drugs has constituted an accompanying problem to anxiety, depression and self-destruction. Drinking is likely to be less serious, although it should not be overlooked.

12. Even though apparently "accidental" one should be alert to instances of self-poisoning behavior. Frequently, the same child will continue to poison himself repeatedly and have to be gavaged. Ultimately, this behavior will result in self-destruction.

13. Homes in which the professional suspects child-abuse or the so-called "battered child" syndrome are serious cause for concern since there is a mounting body of clinical evidence which indicates that future violence can evolve including suicide as a result of these early experiences. If the child feels openly rejected by his parents, it should be noted, even if severe physical punishment is absent.

14. Look for something in the youngster's behavior or talk suggesting that he wants to get even with his parents. A prominent component in suicidal behavior is the wish to take one's own life in order to make those left behind sorry that they did not treat the victim better when he was alive.

What To Do or "Psychological First-Aid"

1. Listen.
   The first thing a youngster in the throes of a mental crisis needs is someone who will listen and really hear what he is saying. An effort should be made to really understand the feelings being expressed behind the words.

2. Evaluate the lethality or seriousness of the suicidal thoughts and feelings of the youngster.

3. Evaluate the intensity or severity of the emotional disturbance.
   It is possible that the youngster may be extremely upset but not suicidal.

4. Evaluate the resources available.
   The individual will have both inner psychological resources such as various mechanisms for rationalization and intellectualization which can be strenghthened and supported and the individual can have outer resources, that is the resources in his environment such as ministers, relatives and other people whom one can call in.

5. Take every complaint and feeling the youngster expresses seriously.
   Do not dismiss or undervalue what he is saying. In some instances the difficulty will be presented in a low key, so to speak, but behind it will be very profound and serious distressed feelings.

6. Act definitively.
   Do something tangible; that is, give the youngster something concrete to hang on to, such as arranging for him to see someone else or whatever seems appropriate. Nothing is more frustrating than to leave the office and feel as though the youngster has received nothing from the interview.

7. Be affirmative, perhaps even authoritarian, but supportive.
   Strong stable guideposts are extremely necessary in the life of a distressed individual. In other words, provide him with some strenghth by giving him the impression that you know what you are doing and that you intend to do everything you can to prevent him from taking his life.

8. Do not be afriad to ask directly if the individual has entertained thoughts of suicide.
Experience shows that harm is rarely done by inquiring directly into such thoughts. As a matter of fact, the individual frequently welcomes it and is glad the therapist or counselor enabled him to open up and bring it out.

9. If the individual does admit seriously entertaining such thoughts and then intends to be euphemistic about it and say he is alright, do not be misled by this.
Frequently on second thought, the individual attempts to cover it up but the thinking will come back later.

10. Do not be afraid to ask for assistance and consultation.
Call in whomever is necessary depending upon the severity of the case, e.g. the school psychologist or whomever may be in a position to render assistance immediately. Do not try to handle everything yourself but convey an attitude of firmness and composure to the youngster so that he will feel something realistic and appropriate is being done to help him.

Since a youngster spends the major portion of his day-time, waking hours in school settings, the school counselor is in a good position to be on the front lines of much of his behavior and stressful activities. The school counselor can be of inestimable value in meeting the crisis needs of youngsters on the spot.

In addition to the material contained in this article, it is recommended that school counselors acquaint themselves as thoroughly as possible with all the relevant information to date in the field of suicide prevention and crisis intervention. It will be well worthwhile and can be rewarding both personally and professionally

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