PREVENTING SUICIDE CONTAGION: BETWEEN A ROCK AND A HARD PLACE

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ABSTRACT: This exploratory longitudinal case study was designed to observe the reactions, over time, of three adolescents who displayed suicidal and self injurious tendencies. Music and other media products promoting self destructive values had been confiscated from each of them during their placement. A year later, all three were discharged home. One of them subsequently committed suicide. Postvention measures were systemic and organized around the needs of the ex-clients' communities, incorporating their active involvement in the clinical process. This study shows how suicidal clients can remain at high risk and continue to need close supervision in times of transition.

INTRODUCTION

At some point in their practice, most child and youth care professionals are confronted with young people who are enduring such great psychological pain that they want to die. Suicidal talk is always an indication of significant psychological distress and needs to be taken seriously. Young people placed in reception centres are more likely than others to exhibit suicidal tendencies because of a greater incidence of suicidogenic factors in their lives.

This study began as follow-up of three clients after their music and media items, which advocated nihilist and self-destructive values, were taken away from them. The girl and the two boys were 15 to 17 years old, and all had a history of self injurious behaviour and suicidal ideation. At the time, all three were placed in the same therapeutic group home of nine youngsters.

Intervening with counselling, by using the material as a starting point, was ruled out because it was seen as risky. Each youth was instead evaluated on the basis of the suicidal risk that s/he presented. A grid was created to systematically account for all major risk factors. The decision to confiscate the material was based on the notion that the content of the music could only exacerbate an already poor state of mind. All three clients reacted to the intervention in their own ways. Their placement came to an end and was understood as successful: the behaviour that brought them into placement had subsided.

Approximately one year later, one of the three youths committed suicide. Managing the grief experienced by his family, youth, parents and staff became the priority.

A postvention process was implemented by the therapeutic team. Support for all the concerned clients (including the parents) and staff members was critical in preventing potential suicide contagion. In response to this terrible event, a systemic model of community postvention was used. It was managed with sensitivity by a small team consisting of child and youth care workers and a social worker.

In terms of the original research design, what had begun as an exploratory study of a simple daily intervention became transformed to include the documentation of a repair process. Although the original idea seems unimportant compared to the unfortunate loss of a young person, we continue trying to understand what could have been done clinically at the time of the original intervention, and if and how we could have foreseen the suicide.

INTERVENTION

The method of this exploratory study was determined by the natural events, as it is in the study of suicidal behaviour. Faced with three clients whose music and clothing advocated self destructive and nihilist values, it seemed natural to confiscate material which could exacerbate their already fragile states of mind. That decision was made, however, following an assessment of their degree of suicidality.

The Two Rock Stars Promoting Self Destructive Values

Marilyn Manson, leader of the band with the same name, uses harsh contrast and images of decay in his music. His band's name comes from combining Marilyn Monroe and Charles Manson. In his autobiography, *The Long Hard Road out of Hell,* the band leader describes himself as an antichrist with a mission against the system, a mandate mainly serving his own personal goal—to be a successful rock star. The band's live performances include sado masochistic sexual acts performed with blood, drugs, broken glass, animal guts and other dangerous props. The band's sound is harsh and metallic. The lyrics describe mental decay and advocate complaisance with psychological misery:

> (...)There is not much left to love
> Too tired today to hate
> I feel the empty
> I feel the minute of decay
> I'm on my way down now,
> I'd like to take you with me(...)

Kurt Cobain, leader of the band Nirvana, died by suicide at age 27 in 1994. In the rock world he is considered a genius, as significant as John Lennon for his contribution to popular music. With an inventive use of

the guitar, he launched the neo punk movement and he promoted the anti fashion trend by showing up on stage wearing torn jeans and dirty, badly cut and poorly dyed hair. Kurt Cobain, a bad boy of the stage, was a child from a broken home. He had been suffering from depression, chronic stomach illness and drug addiction, all of which contributed to his suicidal condition. His songs spoke mostly about disillusionment, despair and powerlessness and appealed to a young audience. He sold 10 million copies of his first album. An example of some of his lyrics follows:

"(...) What else should I write
I don't have the right
What else should I be
All apologies
In the sun I feel as one
I'm married, buried
All alone is what we are(...)"

Profiles of Youth at Risk

A: A is a 15 year old boy who listens to the music of Marilyn Manson. He has posters in his room, wears a T-shirt with the artist on the front, listens to the music, wears only black clothing and uses black nail polish. A is fascinated by satanic rituals and the gothic sub-culture. The reason for referral is depression related to a long chronic illness. This illness resulted in abuse of his prescription medication, temporary disfigurement, and deterioration in family functioning. A also has a history of self mutilation and poor school attendance. As a consequence of losing touch with school and friends, he became incapable of going out and spent very little time socializing. He declared himself heterosexual though he was sexually inactive. At home, his mother is depressed and has been suicidal. Her boyfriend, who lives with them, is mentally ill and there is ongoing psychological violence in the home. A year before his placement, A's favourite uncle had passed away.

A's mother comes to meetings and engages in therapy but colludes with her son when he asks her for more medication, getting him more than what is prescribed. Since the illness has long been a reason for A not to go to school, there is a pattern of poor attendance and it is a challenge to motivate him. The family background reveals a history of crime, alcoholism, and child abuse spanning two previous generations. The level of community integration is weak. The family is originally from a rural area where involvement with the system carries a stigma.

B: B is a 16 year old boy. He likes the music of Marilyn Manson, wears long black clothing, black nail polish, lots of massive jewelry and body piercing. He was referred for being verbally aggressive, self mutilation,

and making up stories while bragging excessively. He also hears voices occasionally. However, apart from the occasional bragging, B's orientation in reality was fine, so mental illness was ruled out. B's behaviour problems were precipitated by the death of his father. The gravity of B's father's illness had been kept from him and when he passed away, B was kept away from the mourning process and the funeral. B had excessive difficulty reading. Severe dyslexia was eventually diagnosed and also explained a lot of his resistance to attending school. B's physical health was rather good and, like his late father, he refused any kind of medical treatment. He claimed he was well connected with friends in his community. He also claimed he was sexually active but not in love. B usually carried on with a "macho" style and claimed to have taken part in the beating of some gay people.

His family situation was relatively stable although the mother remained overwhelmed with the reorganization of her life, the maintenance of the household and two adolescents. Her involvement in therapy was distant at best. Initially, his mother admitted him into treatment reluctantly and only because she was discouraged with his aggressive behaviour. When it subsided, the mother distanced herself from the therapeutic process. She too came from a rural area where it creates a stigma to confide in the system.

B's self destructive behaviours were not life threatening but consistently mildly destructive, like not covering his hands while doing harsh work, picking his scabs, writing extensively on his hands, pushing pins in his epidermis and grossing out others. In his peer group, however, B was often seen as a protector of the weak, a big brother. Fascinated by the graphic violence of the gothic sub culture, he showed a soft side, displayed by his patience and his taste for soft music.

C: C is a 15 year old girl referred to residential care after a history of drug abuse and prostitution. She runs away constantly and exhibits oppositional traits. Her physical health is fragile as a result of hard drug use. Her eating habits are poor and she has many nightmares. Her performance in school is hindered by difficulties in concentration as a result of her drug use. Although she has good social skills, she maintains contact with an old boyfriend who had a severe problem with substance abuse. C is clearly heterosexual. She tried a homosexual relationship and says that she has emerged knowing herself better as a result of the experience. Sexual assault has left her afraid, despite a brave facade.

Although secretive, her mother makes good use of therapy learning how to parent her daughter more effectively. However, on weekends, she allows her daughter freedom that the social worker would not approve of. The biological father maintains a lot of animosity towards the mother. When he meets his daughter, he always speaks badly about the mother. C is always being put in the middle of the parents.

Degree of Suicide Risk

Pronovost & Leclerc (1998) surveyed the suicidal ideation and behaviour of young Quebecers in care, and developed a grid for evaluating suicidal risk. Clients A, B and C were evaluated according to this method (see Table 1).

Table 1
Suicide risk for clients A, B, and C using the Pronovost (1998) criteria

Risk factors	stressors = X		
	A	**B**	**C**
Health (physical & mental)	X		X
School	X	X	X
Friends	X	X	X
Love		X	X
Homosexuality		X	
Self mutilation behaviour	X	X	
Suicidal/at risk behaviour	X	X	X
Family situation	X	X	X
Engagement of parents in therapy	X	X	X
Hospitalization history	X		
Family background	X	X	X
Recent losses/anniversaries	X	X	X
Integration in the community	X	X	X
Cultural issues	X	X	
Spiritual quest/Sub-cultures	X	X	X
Placement & legal matters			
TOTALS	**13**	**13**	**11**

Once each case was assessed in this way, there was no hesitation to remove potentially dangerous items. The risk factor score was extremely high for all three clients. Their family situations remained fragile, and their behavioral gains were not consolidated. Each confiscation event was treated separately and each generated a different reaction.

Responses to the Confiscation

When A was asked to remove the items from his wall, he offered little reaction. He responded with a mere shrug of the shoulders and postponed any verbal response until later. The task didn't get done until an educator went in his room and had him remove posters from the wall

immediately. When the procedure was explained to him, he found it far-fetched but did not argue.

When B was asked to remove the items from his room, he was angry but complied. However, he left one item on the wall as if to check if the staff were observing. This was followed with more acting out. He brought more items to the unit to be confiscated such as knifes, tools, an unloaded fire arm, and drug related paraphernalia. Despite the need for ongoing confiscations, B's relationship with his mother stabilized and his presenting problems subsided.

When C was asked to take down the material from her room, she had a very angry reaction. She made a complaint to a user's committee, she said that she would get a tattoo of the artist's face on her body, and was basically unable to let go. Unlike the other clients, she was allowed, as a compromise, to keep a small photo of Kurt Cobain. She was to keep it in her pocket, for her benefit only, not for others. The compromise appeased her yet she complained each time she thought about it.

The placement of all three youth ended. The intensive combination of placement, family therapy, specialized programs, psychiatric services, art therapy and special school setting offered by the unit seemed to be effective because in all three cases their behaviour had improved. All three clients initially successfully reintegrated into their homes. The confiscations were far behind, if not forgotten.

A Year After Discharge

A and C maintained contact by telephone. They both came to their program graduation party. Both quit school but their lives were relatively stable. A has had a few other crises since then. Although he refuses any on-the-record arrangements, he has successfully sought the support of the group home staff and facilities. His therapeutic involvement has never been as good as since his follow up officially ended.

As for B, he almost severed the contact at the time of discharge. His integration in the community seemed to have flourished as he was spending significant amounts of time at the local Teen Centre. Despite a series of tutoring sessions obtained for him by the unit teacher to facilitate his integration into the new school, B was unable to follow the curriculum because of a lack of resources at the School Board. His follow-up period had been over for a few months and the extra support provided by the unit was insufficient. B did call a few times but the conversation was minimal. He had a girlfriend. He did not come to his graduation.

Several weeks later, B and his girlfriend changed into gothic style clothing, put some make up on themselves in the style of Marilyn Manson and committed suicide. The plan had been carefully prepared and put into place.

All three clients had scored extremely highly on the grid of risk factors—that is 11 or 13 main stressors out of 16. One client committed suicide. This was consistent with the results shown by Pronovost & Leclerc (1998).

This also confirms that "the correlates of suicidality reported in the literature suggest a stress model, which postulates that the cumulative effect of stressful life events causes a pathological response by overtaxing the normal adaptive capacities of the individual." (Rubenstein et al, 1989)

An official report prepared by a committee representing medical doctors and youth workers of Québec (1999) shows that many young people commit suicide shortly after having consulted a doctor or another agent of the social system.

In her study on gender and suicidal behavior, Canetto (1999) found that American adolescents find it inappropriate for a male to survive a suicide. B had a tendency to boast—undoubtedly to cover up low self esteem. The means of suicide chosen by B was impossible to survive.

These risk factor scores show the importance of assessing risk on a individual basis. There is also a need for cooperation between different intervenors at times of transition, especially when the clients have a change in placement or get discharged home.

POSTVENTION

Managing the results of a suicide is a thankless task. The professional staff involved, while experiencing their own pain, must protect other community members by helping them cope with grief. The unit's team took charge of informing B's peer group and sharing the circumstances of his death. A systemic model of intervention was applied to postvention, as this was already widely used by the team. As it often happens, key members of the team were on vacation. So although professional help was available to the team, as was as a draft of the official agency protocol, some members of the team felt that the team had been left "on their own" to deal with this very difficult event.

The team was able to draw from its internal strengths. Mutual support and professionalism bound the staff team and even ex-team mates who joined in to help out. Six months later, the team members who were involved in implementing the postvention recalled the factors that allowed them to extend their process into the community.

The initial shock of the news of a suicide can be, in itself, a trauma. Staff members who are exposed to this occupational hazard must be inoculated against the effects of post-traumatic stress disorder. Immediate support is mandatory because, for the staff member, a suicide represents the loss of an individual, as well as a failure to have safeguarded someone entrusted to his or her care. For the clients who lived with and befriended the youth who committed suicide, the news can trigger different types and intensities of reactions. The parents of these young people, also clients themselves, were to be informed strategically. They remained the key players in this process, given that all clients had returned home.

The first step (before any process could take place) was to call the bereaved family and acknowledge their wishes. It was felt that ethics demanded that staff respect the wishes of the bereaved mother. In this

case, the mother wanted to inform only those who needed to know of her son's death. This arrangement was consistent with the need to protect B's peers and others around them from a potential contagion effect.

Identifying and listing the people who might be at risk (clients, ex-clients, parents, staff, ex-staff and so on) was a team process, and took the form of a brain-storming session.

Announcing the suicide to the various people required a team effort and careful planning. "Who takes care of whom?" was a critical question and most often was determined by the type of relationship the individual had with the staff announcer prior to this event.

Weaving a safety net would probably be the closest analogy to the spirit in which the sequence of events was planned by the team.

"The first line" was moved to the parents. They were the first to be informed and they were the ones to decide if they wanted their children to be informed as well. Some special conditions had to be planned for the parents who the team knew would react strongly.

Coping with the grief reaction, whether it was the staff supporting the parents or the parents supporting their young, was the main task shared by all. Knowing, informing and sharing the signs of grief were ongoing processes. The parents were to be supported and coached on an ongoing basis, either by telephone for occasional support or by participating in an ongoing parents' support group. They were made aware of the ways in which young people can express grief, which is often different from the way adults do it.

All involved in the process were warned against some usual mistake, such as a tendency to glorify the act. A common response among youth who just lost a peer by suicide is: "S/he had the courage to do it" (most often referring to suicide as a way to stop the pain). Staff member questioned the idea that this was courage, given all the pain that it had caused. By doing this staff were able to express some of their own anger at the suicide. At the same time, such responses invalidated the notion that suicide is self-expression, acknowledged the pain the suicide was creating for others, and let clients know that being angry is OK.

In other cases, staff members with shared faith used other gentle means of normalization determined by their spiritual experiences and values, and their philosophical outlook. In the face of an event as abrupt as suicide, the values which guide us become evident because without understanding the reasons for the act, we need to invent them. The projection which takes place in these exceptional times does not have to be only a source of pain; it also provides an opportunity to affirm the fundamental messages we want youth to absorb: you are important, you are not alone, others care about you.

The day of the funeral, the main strategy was to pair up everyone involved, indiscriminately mixing clients, parents and staff from different programs. This way no one would end up alone during the ceremony. This also put each person in the role of a helper as well as that of a griever.

After the funeral, people gathered for lunch in a restaurant. It provided space: to grieve and to reflect; for the youth to reconnect; to make sense with each other of what had happened; and to recognize how much they had grown and changed since they had met. It was a time to grieve by telling stories that bound them to this boy, which in turn positioned themselves with regard to B. He used to protect them, now they were surviving him.

Everyone left with the task to support another person in the group, a reason to reconnect by telephone or by some other means, and get some news; which created a kind of a collective vigil. Some clients emerged as natural leaders; when they felt that another youth was at risk they took the initiative of visiting him or her and keeping in contact. One client suggested to the team that another youth be informed. She knew how much B had meant to the other youth and wanted to be part of that process. Since it was judged clinically sound, it was done the way she suggested.

Contact was maintained during the first month. The plan was to reconnect after six months, then after a year. This was done to the extent that clients were agreeable to the contact.

Getting outside help for the team was also a delicate matter. The principle of not forcing therapy onto a client was applied to the bereaved staff members. Some welcomed the debriefing process more than others. The feedback provided in the session had the effect of alleviating some of the pain by multiple means, whether it was by venting, expressing sadness or listening to others; eventually it was well received by all staff. Of course individual support was also offered confidentially to staff.

DISCUSSION

Initially this research was intended to document the reactions of the three clients to the confiscation of media products. Removing certain items was judged the safest intervention in order to eliminate factors which could contribute to suicidal risk. It was noted that each youth's reaction was typical of his or her usual behaviour and was representative of the progress that had, or had not, been made. In fact, risk assessment, based on a list of predictive factors, showed that even without these items, all three youths were at great risk (Pronovost & Leclerc, 1998).

What is at stake here is the question of imitative behaviour: how powerful is it? Do the products trigger imitation or is it simply representative of what the youth is feeling?

A symbolic interpretation would view the consumption of these products (music, art, etc.) as indicative of malaise that was there in the first place. Trapped by difficulties in expressing themselves, young people find sounds and lyrics that describe their feelings. If the use of these products is perceived as a symptom, it could, like any other type of acting out, open up a dialogue which in turn could lead to an appropriate intervention. By discussing lyrics and the form of the media, the client is placed in the expert role and the power that is usually part of the child

and youth care worker's role is put aside to allow for a clearer understanding of the youth's state of mind. The cultural product becomes a basis for communication instead of the cause of a battle. It becomes non-threatening, creating a means of exchange and an opportunity to discover the dispositions and the intentions of the client. (Carrière, 1999)

Removing items and products is an intervention based on the assumption that the worst could happen. However, this type of intervention can give the young person the message that what they are trying to say is not important. Moreover, by dismissing the choices they make, we might miss out on a occasion to connect and, most importantly, to communicate that we care. "...[W]e in the helping profession have a faulty grasp of the role of tribulation in shaping character. We quickly advise the victim what to do instead of helping the person grapple with developing personal strategies to cope" (Murphy, 2000). Addressing the content of the products can easily turn into a discussion about moral and aesthetic values; and become an occasion to enhance abilities rather than emphasize weaknesses.

This problem should not be debated simplistically. One must take into account variables such as: how is the youth is using the product; what are the cultural variables; what access does the youth have to these products what are viewing habits at home, etc. Other variables, such as the understanding of the concept of death and its irreversibility, also play an important role (Mishara, 1998). These should be further investigated, especially given the regression that sometimes results from the high stress experienced by clients undergoing placement .

An organization operating on a systemic philosophy needs to acknowledge the importance of media products. They are an intrinsic part of youth leisure nowadays. We cannot afford to ignore this growing reality which is now part of our daily practice. The consumption of media products is to be taken very seriously. Each organization could benefit from formulating a clear stance towards the viewing of certain media products and computer games. However, a critical component is also and the processing with the young person that is often needed afterwards.

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