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CONTEMPLATING SUICIDE: RISK, RELATIONSHIP, AND RECOVERY

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ABSTRACT: A case study approach is used in this article to discuss two different approaches to suicide prevention. The population health approach to preventing suicide is applied to a community case study by analyzing the risk and protective factors inherent in that community and suggesting preventative actions. The crisis prevention approach is applied to two individual case studies to consider the individual and systemic risk factors as well as the precipitating factors that contribute to the possibility that a youth will view suicide as an option for dealing with life's troubles.

When I was 20, a neophyte child and youth care practitioner; I remember taking Celeste (16) to the hospital to have 100 Aspirin pumped from her stomach. Celeste didn't have a lot of reason to live. She had already spent at least 6 or 8 years in and out of care, including a very large institutional setting, prior to the group home where I got to know her. Her mother was mentally ill and her 18-year-old sister was pregnant with her third child, having aborted the other two. Poverty was a significant factor in her life, and I do not recall anyone ever saying who or where her father was. I sat with her while she met with her psychiatrist who turned to me said "You must be very angry at her for having done this to you." His comment puzzled me. I got angry when she pushed me around or sullenly refused to do her chores or participate in the home's activities, but this suicide attempt did not seem to be something that did or should make me angry. Celeste on the other hand, was VERY angry about life and had chosen suicide as a means of trying to stop the pain. She had crossed the line in our society that says that life is sacred and not to be taken at your own hand. I too had crossed a line.

There are two types of child and youth care practitioners; Those who have sat with a suicidal child, wondered what to do and felt the fear when that child left the hospital, and those who will do so in the future. The irony of this became clear to me when I reviewed 16 public reports on youth who had committed suicide by the Office of the Children's Commissioner in British Columbia (Canada). Of these youth, 62.5% (10) had been involved with and placed out of home by child welfare authorities. By comparison, I interviewed 23 youth who scored high on a suicide risk screen, (some of whom had previously attempted suicide); some with incredible histories of violence, and only 13% (3) mentioned child welfare

involvement or indicated being placed. We may not like to admit it, but our youth in care are statistically at much greater risk for killing themselves.

Celeste came to visit me when she was 20 and I was now an " experienced" child and youth care practitioner. She went to considerable trouble to figure out where I was, more than halfway across the country, and to get herself there. We chatted about how she was doing and what she was up to now. It was good to know that she was still alive. A few years later she was featured in the local paper; an unemployed sales clerk who was taking on city hall, trying to improve the water quality and stop the raw sewage dump into the river. According to the research on suicide risk, statistically speaking, she should not have been there to visit me or to take on city hall. Celeste had a way of finding relationships with people who would go out on a limb to help her. This tenacity, the constructive use of anger and her ability to seek out support from others who could help her, likely contributed to her surviving the pain that led to her suicide behaviours. Something else was required though; those that she sought support from had to respond. They had to have the desire to be with her, and help her get what she needed. She also had to care enough about them, not to leave them in the process of working through the pain.

SUICIDE PREVENTION

Between 1988 and 1992, the annual suicide rate for youth (ages 15-19) in Canada was 13.1/100,000. In the 20-24-age range, it was 18.4/100,000. In both age ranges, males were 5 times more likely than females to kill themselves (Tierney, 1998). In 1993, in Edmonton, Canada, an estimated 805/100,000 youth (ages 15-19) attempted suicide. The rate for those ages 20-24 was 491/100,000 (Bland, Dyck, Newman & Orn, 1998). Interestingly, the number of attempts for males was similar in both age categories, but there were far fewer attempts by young women in the 20-24-age category. According to these statistics, our success rate at keeping youth who attempt suicide alive is about 62:1 for 15-19 year olds, and 27:1 for those ages 20-24. Although there are fewer attempts in the older age range, there are more completed suicides.

When you, as a practitioner, first meet youth you listen to their stories and you get to know them. The stories tell you about the 'risk' and 'protective' factors that are part of the youth's life history and which may contribute to suicidal behaviour. Getting to know them and caring about them will enable you to know when you need to act to prevent suicidal behaviour and what you need to do. Most youths have many other issues and concerns and may come with a psychiatric diagnosis. They have an intervention plan, or one is developed. Rarely do they come with a flag that says "imminently at risk for suicide" because being suicidal is a temporary state. Yet, the risk factors are always there and one must

constantly be working on prevention. As a practitioner, you must always be thinking about the prevention of a suicidal crisis and if one, you work to prevent the youth's death.

This paper considers suicide prevention from two perspectives. I present several case studies and an analysis of those case studies. I hope this will prompt the reader to consider what steps that can be taken, on a daily basis, to prevent suicide. The cases are all developed from real people and real places. Some information has been changed to protect the community and the youths concerned, but nothing that significantly alters the outcome of the cases, as I knew them.

The Population Health Approach to Prevention

The population health approach to prevention focuses on reducing the suicide rate by reducing the incidence of new cases among the youth population. Research has demonstrated that the factors statistically associated with an increased risk for suicide behaviour amongst youth include: depression and other psychopathology; substance abuse; early trauma such as sexual abuse; exposure to suicide behaviour (in particular completion) by known role models; access to lethal means (e.g. firearms); family strain; and community strain, particularly in the area of poverty contributing to lack of control over one's future (Berman & Jobes, 1994; Berman & Jobes, 1995; Cooper, Corrado, Karlberg, & Pelletier Adams, 1992; Kirmayer, 1994; Ladame & Wagner, 1994; Lewis & Lewis, 1996; Spirito & Overholser, 1993; Thompson, Moody, & Eggert, 1994). There is little research on the relationship between these risk factors and an individual's progression toward more life-threatening behaviour, although being young, male, and aboriginal with access to firearms are all factors that are more strongly associated with completed suicides.

Protective factors for suicide behaviour include religion (Greening & Dollinger, 1993) and the development of youths' skills to manage depression, anger, interpersonal problems, and substance misuse (Eggert, Thompson, Herting, & Nicholas, 1995). The control of environmental factors such as access to means is also important (Berman & Jobes, 1995).

Protective factors and risk factors can be organized into a scheme that identifies protective, predisposing, and precipitating risk factors (White & Jodoin, 1998) within the systems and conditions that youth at risk for suicide are dealing with. Table 1 summarizes the risk factors and the protective factors that contribute to increasing or decreasing suicide rates in the youth population.

Table 1: Risk and Protective Factors

	General Predisposing Risk Factors	Specific Contributing Risk Factors	Protective Factors
INDIVIDUAL	• Previous attempt • Psychopathology • Prolonged grief • Sexual abuse	• Rigid thinking • Limited problem solving skills • Substance abuse • Gay/lesbian issues • Impulsivity	• Easy going, optimistic • Creative problem solving • Personal autonomy and mastery • Sense of humour
FAMILY	• Family history of suicide, violence, psychiatric disorder • Early childhood loss	• Family substance abuse • Instability • Ongoing conflict	• Close to family members • Adults model healthy adjustment • High, realistic expectations
PEERS	• Social isolation • Teasing	• Engage in risky or maladaptive behaviours • Negative attitude toward help seeking • Lack of long term relationships	• Acceptance and support • Competent friends • Help seeking behaviour is valued
SCHOOL	• History of school failure, learning problems • Lack of connection to school	• School disruption during key learning periods • School staff that prefer not to think about suicide	• Parent involvement • School activities • Caring atmosphere where adults believe in youth's ability
COMMUNITY	• Legacy of suicides in community • Marginalized people • Political disempowerment	• Sensational media portrayal of suicide • Access to firearms • Limited community resources • Poverty • Racism	• Youth participation • Community self-determination and volunteerism • Community hope • Available resources

(Adapted from: White & Jodion, 1998)

The population health model of prevention determines success by measuring changes in the suicide rate of the youth population (Berman & Jobes, 1995; Coggan & Norton, 1994; Malley & Kush, 1994; Silverman & Felner, 1995a; Silverman & Felner, 1995b, Spirito & Overholser, 1993; Vince & Hamrick, 1990; White, 1997). Typically, prevention programs target the general risk factors noted in Table 1 in an attempt to reduce the incidence of the risk factors or minimize their impact. By eliminating risk factors and enhancing protective factors, the statistical probability that a youth in a given community will commit suicide, or engage in suicide related behaviour, can be reduced.

First generation prevention programs have been criticized for several gaps in their efforts. Critics indicate that public health approaches are lacking in several areas:

1. The links that they hold to other community resources such as mental health centres and risk prevention programs (e.g. substance abuse) are weak.
2. There is a limited focus on means restriction.
3. Evaluation research is lacking (Berman & Jobes, 1995; Potter, Powell, & Kachur, 1995).

In addition to these criticisms, I would suggest that the population health approach fails to take into consideration the importance of relationship for youth. Addressing the contributory risk factors noted in Table 1 requires a different approach. Prevention approaches such as peer helping and youth participation in community development activities can enhance the relationships that exist among youth (Stuart & Haelstromme, 2000) and as such, youth feel connected to each other and less hopeless or alone in dealing with the issues of adolescence. These types of prevention activities along with suicide awareness education; clear school policies on suicide and gatekeeper training at schools and in the community; restricting access to firearms; media education on reporting deaths; and strong connections among helping resources can build a strong network that reduces the statistical probability of death by suicide.

Crisis Prevention Approach

A second approach to prevention focuses on rehabilitating one particular youth and intervening in a suicidal crisis. The crisis prevention approach tries to eliminate or resolve precipitating factors (White & Jodoin, 1998) that trigger a suicide attempt. These factors, too, are part of a layered, systemic perspective as illustrated in Table 2.

Table 2: Precipitating Risk Factors

	Precipitating Risk Factors
INDIVIDUAL	• Failure or perceived failure • Trauma • Developmental crisis (may re-activate an old trauma) • Under the influence of drugs or alcohol
FAMILY	• Loss of significant family member • Death, especially by suicide
PEERS	• Teasing • Loss of relationship • Rejection • Death, especially by suicide
SCHOOL	• Failure • Expulsion • Discipline Crisis
COMMUNITY	• High profile death in community (or of role model) • Legal conflict

(Adapted from: White & Jodion, 1998)

Crisis prevention is what is done to keep the youth alive. Typically, it involves a suicide risk assessment of the immediate danger. Risk assessment involves more than evaluating factors in the person's background or personality that are statistically associated with suicide behaviour. Crisis prevention also means developing trusting relationships that allow a youth worker to understand the individual's perceptions and thoughts, and to talk openly and honestly about the youth's plans for killing him or herself as well as the pain the person is trying to escape. It requires remembering that pain is relative, and that one must accept the subjective reality of the person in front of them.

The crisis prevention approach to assessing suicide risk identifies the following factors as critical:

1. The person is experiencing significant pain or stress as the result of a single event, or as the result of several events over time. Loss is a common theme: loss of a job; loss of a relationship; a death in the family; failure at school; repeated moves; separation from family abuse or assault—these are all losses to the individual involved;

2. Changes in thinking that make suicide an acceptable option for dealing with the pain;
3. A specific plan, including method, time, and preparations already completed;
4. Lethality of the method chosen and access to the method;
5. Extent of prior suicidal behaviour or risk taking behaviour;
6. Presence of impulsivity and/or substance abuse that would reduce the inhibitions and increase impulsivity; and
7. Social isolation: limited friends or family and superficial relationships.

(Ramsey, Tanney, Tierney, & Lang, 1994)

The number and intensity of these factors is directly proportional to the likelihood of an attempt and the chance that the youth will die. Success in the crisis prevention model requires alleviating the suicide behaviour for a particular youth (Berman & Jobes, 1994; Kerfoot, Harrington, & Dyer, 1995; Potter, Powell, & Kachur, 1995). Prevention techniques include: no-suicide contracts; hospitalization; 24 hour monitoring; crisis counselling and anti-depressant medication.

The focus of prevention activities from either perspective can occur within one or many of the systems in which the youth participates. The remainder of this paper applies the systemic framework of risk and protective factors to assessing communities and individual cases to provide targeted interventions.

THINKING SYSTEMICALLY AS AN APPROACH TO PREVENTION

In order to understand the problems and resources of the youth population in a given community and to successfully intervene, we have to consider the environment and the systems in which youth interact as well as the nature of their relationships. Working at both approaches to prevention at all times allows us to develop a continuum of prevention activities.

Within a given community, practitioners should assess the presence of risk and protective factors among the total youth population. Prevention programs must then modify these factors for all youth. At the same time, subpopulations of youth where particular risk factors (e.g. family violence, poverty, substance abuse) are more prevalent should become the recipients of targeted interventions to deal with these issues and develop their coping skills. Prevention practitioners working with youth must be alert for the need to shift to crisis prevention and/or a more intensive intervention focus for a particular youth.

The following three case studies are presented and then analyzed using the risk and protective factors framework. Prevention strategies using the continuum are suggested in each analysis.

The Case of Northtown

The townspeople and service providers are concerned. Seven suicides of youth (ages 20-24) from the town of 12,000 in the last 2 years include young men known to have been sexually abused by a school principal who was charged and convicted several years ago. What could be done, if anything? Was the abuse the key or were there other factors?

The town is located at the end of a beautiful fjord about 60 km from the next largest centre. The area is mountainous and heavily forested. The fjord, known throughout the country for its hot springs and rugged untouched wilderness, attracts a significant tourist industry in the summer. Sport fishing and logging have gradually replaced commercial fishery. The town was built in the early 50's, by a mining and manufacturing company who imported labourers from eastern Europe and, more recently, India and the Pacific Rim. The industry base is stable with mining, manufacturing, logging, and oil production providing local employment. The unemployment rate for youth and adults is low and the average income well above the poverty level. Advanced education is readily available.

There are many separate cultural associations, most of which are informal groups that meet irregularly and promote their language, knowledge of the home country, and support for new immigrants. The Multicultural Society promotes multiculturalism in the community and interest in the society ebbs and rises over the years.

There is a strong interministerial group representing United, Catholic, and Protestant faiths, a Sikh temple and a small group of Jehovah's Witnesses. There is a separate school (K to 7) for Catholic students and a First Nations operated school (K to 7) in the nearby Village.

Youth tend to cluster with their own ethnic groups, although not to the exclusion of those with different backgrounds. First Nations education courses on language and culture are offered in the School District. Such programs have been present in the Aboriginal Community School since its inception. There is a drum and dance group and First Nation basketball and soccer tournaments are separate from the mainstream sports leagues.

Sports activities are the primary source of recreation in the town. The major industries provide employee subsidies for recreation programs. Figure skating, hockey, competitive swimming, basketball, karate, volleyball, racquet sports, hunting, fishing, and hiking are popular. The theatre at the high school provides space for performing arts groups. A Youth Centre is available and organises field trips each summer. In the Village, a youth centre and a summer camping program with cultural experiences for native and non-native youth and adults is available.

Yet youth say that there is nothing to do. They want a skatepark, go-cart track, more places to hangout (including fast food) and better shopping opportunities. Their interests are: being with each other, excitement, and food.

Transportation is difficult for many youth. Those who live in a subdivision outside of town and the Village are dependent on parents, friends or siblings for rides in and out of town to visit friends or get the basic goods that they need. The

townsite was planned by an urban planner into several discrete subdivisions and the public transportation system is limited to the actual townsite. There is no public transport to the next town.

Mental Health Services have been described as under-resourced for many years. In an effort to better co-ordinate services a Suicide Prevention and Intervention Committee was formed. There is one Child and Youth Mental Health Counsellor and turnover is high (3 changes in the last 2 years). Psychiatric services, provided once a month, by a visiting psychiatrist are shared with other local communities. Programs for supporting young parents, life skills, parenting teens, children who witness abuse, addictions counselling, school based substance abuse prevention, and pre-schooler development and family support are offered through 4 non-profit agencies.

The Public Health Nurse offers prevention education to the school. Programs and counselling for sexual assault and psychological assessment, as well as hospital admission for mental health crisis, are available in the other major centre, 60 km away. The Village Health Centre offers health services for the Aboriginal people including psychological counselling and assessment, addictions counselling and home support.

Employees and their families at local industries have access to the Employee Family Assistance Program, which contracts with a provider of psychological services to fly in on a weekly basis. This service is available by appointment and a first appointment may take several weeks.

There are two high schools in the community; a mainstream grade 8 to 12 school fed by 7 elementary schools and an alternative school that serves 40-45 students. Students with learning difficulties, social problems, or behavioural difficulties make use of the learning assistance classes at the high school or are referred to a school counsellor, an itinerant counsellor or a First Nations Home-School Support Worker. Students rate school counselors as only mildly supportive. School policies such as calling parents around specific student concerns (e.g. Depression and suicide); assigning school counselors to students in specific grades; and long waitlists are detrimental to students seeking help from school personnel.

Youth live primarily in intact families (70% of the population) and experience a high level of support from parents and a high level of satisfaction with their parent support and peer support. Amongst the youth population, 42% scored a mild (or higher) level of depression, with no differences between boys and girls, on a depression-screening instrument. At least 80% of the high school students have tried alcohol and 51% have tried marijuana. More importantly, at some point in the previous month, 59% had used alcohol and 25% had used marijuana. By grade 12, 39% of students drink on a weekly basis. There is a significantly higher level of substance use at the alternative school. A history of previous suicide attempts is known to be present for 4% of the boys and 6% of the girls and thoughts of suicide were present in 30% of the boys and 36% of the girls.

How to Prevent Deaths by Suicide in Northtown

If we review the risk and protective factors outlined in Table 1, Northtown has a number of factors that can be considered in a risk reduction plan for the youth population. The high level of employment and consequent standard of living represents a protective factor for youth and families within this community. There are likely pockets of poverty, possibly in the First Nations village, and youth who live in those families may be at a higher risk for suicide. The First Nations youth have a history of marginalization and political disempowerment and, as such, are at increased risk. The fact that hunting and other outdoor sports are common activities in the community means that firearms are readily accessible and may pose an increased risk.

The community has a strong set of prevention resources working in the health and social services area, although the turnover in the mental health counselors is of concern particularly since it effects the establishment of relationships with individual youth at greater risk for suicide. The limited availability of psychiatric consultation means that the general practitioners must be relied on to prescribe psychotropic medication and therapy is not available. The legacy of suicides in the community is of concern, particularly since they have occurred among the youth population. The hypothesis that the sexual abuse was related to these deaths is likely correct, but the legacy remains. There are a number of risk factors that can be influenced in a prevention effort.

The school system seems to be well equipped for prevention activities, particularly in the area of supporting the First Nations youth. The youth themselves, though, are hesitant to seek help from professional resources and this attitude may keep those that need help from seeking it. Gilbert (1997), reports that the percentage of youth diagnosed with major depressive disorder or dysthymic disorder is between 8 and 11 %. The percentage of youth in Northtown who screened as depressed is much higher. The separation of the various ethnic and cultural groups encourages strong cultural identity, but may be masking an underlying racism that the community has not addressed. One would anticipate that students in the alternative school would be at higher risk for suicide since they were more prone to failure or expulsion and disciplinary crisis in the mainstream school. The higher adult-student ratio in an alternative school, though, may work to mediate the risk presented by this factor.

Amongst the peer group, teasing and social isolation appear to be factors that may be at work for particular subgroups of youth. The high rate of drug and alcohol use is of particular concern since inhibitions are lowered when youth are under the influence of drugs or alcohol and this is a risk factor for suicide. On the other hand, youth do have an attitude that peers are available and helpful for seeking advice on personal problems.

The community will benefit by the formation of the Suicide Intervention and Prevention Committee as a step toward integrating the resources available and ensuring a comprehensive approach. The more intensive intervention services such as mental health counselling and psychiatric services need to be more strongly developed to manage the crisis intervention cases that may arise as the community implements stronger prevention programming. Programs such as suicide awareness education in the schools and youth centres and additional unstructured activity programs where youth can hangout and enjoy each others company are needed. The schools would benefit from involving youth in an anti-racism movement that is developed by the youth themselves. A media campaign to ensure firearms safety and accident prevention aimed at both parents and youth could reduce the impact of accidental or impulsive deaths. Since youth are more inclined to go to friends for assistance, the suicide awareness program is important; the use of trained peer helpers for basic problem solving in the general population would be effective prevention. Within the First Nations population and at the alternative school, peer helpers, who are more highly trained in recognizing the signs and symptoms of suicide behaviour and quickly connecting youth to adult resources, would be beneficial.

A final word of caution relates to the future of the Northtown. There is a possibility of sudden changes in the overall level of risk. The primary factor to be considered here is the town's dependence on resource industries which could run out, plunging the town into unemployment and removing a number of supportive resources, like the employee assistance counselling and the financial resources available through both the company and the tax base for the town.

The prevention approaches just described will influence the suicide rate within the youth population, by acting on risk factors and enhancing protective factors in the overall population. There is still the risk, though, of suicide behaviour because of the nature of the interaction between population risk variables and the unique circumstances and character of each youth.

THINKING SYSTEMICALLY, RELATIONALLY, AND INDIVIDUALLY ABOUT CRISIS PREVENTION

Practitioners use the crisis prevention approach when they notice indications of suicidal intent. Each of the following individual cases is analyzed to describe the early indications of risk based on the framework presented in Table 2. Crisis prevention should begin on an individual level long before the first indications of suicidal intent. Suicidal ideation is a temporary state; one must think systemically, relationally, and individually about each youth in order to ultimately prevent or resolve the crisis.

Once suicidal intent is evident, the crisis prevention assessment noted previously must be used and a long term intervention plan put in place.

Understanding the individual thoughts and plans of the youth become critical in determining the imminent risk. Hospitalization and/or the use of proximity as a way of forcing relationship may become necessary. Relationship is still critical but at the point of suicidal intent, the youth is incapable of understanding relationship or feeling cared about. The world is black enough that the caring actions of others cannot penetrate or be understood. The crisis intervention technique of contracting is a formal agreement for a relationship, in the absence of the youth's capacity to feel that relationship. The contract formalizes the relationship and temporarily represents it.

In each of the following case studies, the risk factors for suicide are present, as are some protective factors. I will consider each case and assess the risk and protective factors, noting what steps might prevent the crisis of a suicide attempt at some point in the future.

Barb

Barb is 15 and lives at home with her Mom and three siblings. She is the oldest in the family. Her Dad is in the armed forces. He lives across the country in the same town as her grandparents. She is currently in grade 10 at the alternative school in Northtown. Barb has been identified as depressed and at risk for suicide through the school-wide screening. She also indicates a history of sexual abuse.

Barb spent 6 years figure skating and was good enough to compete provincially. She quit 2 years ago at 13, after she ran away and hitchhiked to the capital of the province, 10-hours away. She managed to contact her Dad at that time and he allowed her into his home to stay with him until her mother came and got her. She did not return to school until the next fall and was four courses behind entering grade 9. In March of Grade 9; *I went to Hell, California, and I got a wicked tan, and I lost a lot of weight. So when I came back everyone was like 'oh Barb, you look so good,' you know, and I got a lot of compliments.* Once again, she could not complete the second semester. At this time, entering the alternative school, she has 3 semesters of completed course work in high school and her goal is to complete grade 10 and return to the regular high school by next year. The alternative school allows youth to work at their own pace and offers tangible rewards for good performance. For example, if a set number of lessons are completed, students get Fridays off. Completing a specific number of courses can earn a week off.

Barb finds this town a really awful place to be. She was born in another town and moved several times before arriving in Northtown in Grade 5. She says, *I sit in my room and I just do nothing. I sit there, and like maybe I play Nintendo every now and then but I'm very distant from my family. I never eat supper with them; I don't do anything with them. They're there, I'm here, and that's the way it is. My little sister, she just bugs me, 'why are you doing this, why are you doing that,' you know. And when you're in that point of your life*

where it's just like 'get away from me, stop asking me so many questions,' I don't know why I'm doing this, you know, that sort of thing. I just freak on her. I have no control, none. I'm like get away from me you fat little pig, you know.

Her Mom was 17 when Barb was born and 19 when her father left. She struggles to make ends meet often going without food herself so that the children can eat. Barb occasionally takes a part-time job and contributes to the family income. Barb has just returned from a month with her father. *I don't know exactly what was going on in my head, I was sort of confused and I really did want to get a chance to know my father, right. So, I went out there to.... So he was away for most of the time I was there, and I never really got a chance to know him. Like every now and then, we'd go out for a walk or something and we'd get talking, but it was very awkward. You know, it was like I was speaking to a total stranger about some things that were personal to me.*

Barb's mom is very, concerned. She wants her to see the psychologist. Barb does not believe that she really needs to go, but she is going just for Mom. She would rather just hang out with her friends and do some drugs. *Like for me this town is the biggest drug capital of the world. Like I would do drugs every night. I drink constantly. It sort of, it makes me laugh and so I'm happy and whatever. And then when I start coming down it's like ohhh, you know, and then I start getting back into the, I don't know, I call it the hole. It's like a hole and I can't exactly get out of it on my own.* Barb thinks about suicide, *almost twenty-four hours a day. I think about it, have dreams about it, you know, I wake up and ohhh, I'm so miserable. I have no friends, I have no life, blah, blah, blah.*

Barb is a perfectionist. She likes to put on a good face and act in a socially responsible manner around her family and her friends. Manners, for example are very important to her. *My biggest are dinner table manners, oh gosh, seriously. My younger brother and sister have a big problem with chewing with their mouths open and it drives me up the wall. Oh, just hearing that smack, smack, smack, oh, it's like, oh. It's very, it's annoying. It's crazy. And slurping when people drink. Oh, gosh. Like when people are really, really thirsty they glug, it's like glug, glug, glug. It really bothers me, I have to leave the room. I don't know why these things, but, so that's another sort of [pause] I'm going to leave and let you drink and glug or whatever, I'll see you later.*

She remembers being teased a lot when she was younger. *Figure skaters' legs get very big,...muscular, exactly. And they used to call me thunder thighs, and fat ass, excuse my language, and that sort of thing. In addition, it, after awhile, you know, it's like okay, well, you're saying that, I don't believe you. But after awhile it begins to sink in, well maybe I do have really fat thighs, or maybe my butt is really big, you know, maybe I do have a big nose, that sort of thing. And that's where my self-esteem went plft, it crushed. Like the boys I used to know when I was in grade five, they used to chase me in the back field and stick my face in the snow until I couldn't breathe.*

When she was seven, Barb's babysitter was a youth of 18 who lived in the next townhouse. She would go there after school. The sexual abuse started in March and continued through to June, when she decided that

she could not handle it anymore. She had gone to the home and he started at her, saying that if she told her mom he would just do it more. She ran out the back door, with difficulty and went under the fence to her own townhouse. Her mom was surprised to find her an hour later and while she did not initially believe her, within an hour, she had confronted the boy's mother. Several other young girls came forward with the same allegations. Barb entered counselling for a year to help her resolve the issues. She finds that she has big anger problems currently and is trying to use a 15s rule to count back when she starts to boil. It doesn't always work.

Barb has a wide circle of friends and acquaintances, but only a few trusted friends. *They need to be honest with me and I need to be honest with them. Trust, I need to be able to trust them. I like people who listen but don't give advice. And just respect, you know. If they give me respect, I'll give them respect... I have one or two friends that I do that kind of thing with, and they're the ones that listen and they don't give advice.*

Analysis

Barb has a number of significant risks. While living in a single parent family does not pose a risk, she did experience an early childhood loss when her father left and is evidently still dealing with this issue as she seeks him out repeatedly for a relationship. In addition, the family clearly struggles on a daily basis with finding sufficient income to live on. Barb's history of sexual abuse, the teasing she has experienced at school, her repeated school failure (or drop-out), her ongoing substance abuse, and the depth of her depression and resultant distancing from her family all place her at high risk for suicide ideation. Her description of the "black hole" indicates that suicidal ideation is already a strong possibility and a detailed risk assessment is essential.

Barb's enrollment in the alternative school is a protective factor. She is more likely to experience success and there are more adults with whom she can develop relationships. Her mother's commitment to her is also a protective factor. She is encouraging Barb to get additional counselling and engaged her in counselling immediately after the sexual abuse occurred. It is likely that Barb is experiencing a developmental crisis related to the abuse at this point in time. Her peers appear to provide a resource since there are a number that she relies on and to whom she feels close. If these same peers, though, are engaged in risky behaviour like substance abuse, they may be more of a risk factor.

Barb is not committed to counselling, so the counsellor will have to work on the relationship. Both Barb's mother and her friends could receive some suicide awareness education and training in how to assess her for suicide risk and connect her to crisis resources. They should also learn how to monitor the environment for access to the means for carrying out a suicide plan. Medication to alleviate her depression may help her respond to the counselling she is receiving. Additional income

for the family would relieve the financial stress. Barb's siblings might benefit from help to understand Barb's blackness and methods for disengaging from the conflicts that she has with them.

Christine

Christine is 16 and was placed in this group home 2 months ago. Her Mom and stepfather asked that she be removed from their home when she could not control her behaviour and she was threatening to kill her mother. She has not seen her father for 2 years after she tried living with him, but found that she did not get along with his new wife. The group home tried to place her in a grade 9 class, but she is currently refusing to go. She has not been in school for 2 years.

Christine was born in Northtown and continued to live there after her father left when she was five. Until she was 9, the informal custody arrangements between her mother and father were that she would spend 6 months of the year with each of them. This involved a move and change of schools each time. In addition, her mother was constantly looking for a better or cheaper place to rent. The moves stopped when she was in grade 3, after a child protection social worker suggested to her mother that they were detrimental to Christine's ability to learn. *You try, you get to a new place and you have to get used to everybody. By the time I get used to everybody, I was there a couple of months and everything is different in every single place too. Like your house is different, your friends, you gotta meet them again, get to know them, they might be different. Your school will be different, have to get used to your school, your teachers. Then you get shipped away again and you go to a different place, it just, warps your head. It's like a drama class, you gotta learn how to act with everybody else. You gotta sit there and watch somebody else act and it slowly works it's way to you and then you're watching them and you get used to them and then you don't even realize that you're sort of acting with them too.*

Christine continued to spend summers with father. Her mother remarried when Christine was 14, after a 3-year common law relationship, with the father of Christine's 3 year old brother. The family moved after the marriage to a large urban centre where her stepfather expected to find better employment. Poverty is an ongoing issue for the family. *They don't want me anyway. They've got the baby to look after. My mom is really pushy. She says I've been a problem since Kindergarten, she doesn't like me and she doesn't want me, that's why she kept sending me to my Dad and his 'bitch-wife'.* Following the birth of the baby and her mother and stepfather's move to the city when she was 14, the relationship between Christine and her Mom deteriorated. According to her mother, Christine has always been a behaviour problem. She was diagnosed with Attention Deficit Disorder (ADD) and placed on Ritalin when she was 8. One of the sources of controversy after the move to the city was her refusal to take medication. She began staying out longer than her parents allowed and they suspected drug abuse.

Last year Christine called social services and reported her Mom for child abuse. Because of the parent-teen conflict she was placed in a group home, but she ran away constantly. *I told that f..ing social worker that I don't want to be in a group home. Nobody wants me, there's not much point in living really. She made me an appointment to see a counsellor, but I've seen enough shrinks and they always just put you on drugs that make you feel weird. She moved me after I ran away. They said I was at risk for being sexually exploited and put me in a safe house. What a joke. I was there for 3 months, but they couldn't keep me. The rules were too stupid, who wants to come in by 9 and not tell your friends where you are?*

Christine eventually ran away from the safe house and went to California. *What a great place to go. I spent 6 weeks there. Like, I ran away just to see if I could live on the street. Try it out. I like to challenge things. Just to see if, how many days I can last. People are still thinking, 'little kid can't take care of herself.' My mom paid my bus fare back and I stayed with them for a while. I told my mom I think I'll get a gun a shoot her, she's so pushy.*

Shortly after the trip to California, Christine went to another group home. She continued to run away and once took another girl with her. The staff believed that she was trying to convince the other girl to prostitute so she was moved to a home for street-wise youth. *Just because the cops found me in a hotel with some friends and they had some coke and stuff. I wasn't doing anything illegal! They sent me to a place for street-wise kids, whatever that means. It was pretty scary.* The staff there realized that she wasn't as connected to the street as originally thought and she was returned to the first group home. *This chick tried to get me to hook, so they sent me back to the other group home. I'm trying get them to find me a foster home. The social worker said she'd try. I had to spend Christmas here, cause my folks don't want me. I wrote a lot, poetry and I have my diary that I keep. I'm not really sure that there is much point to living. Nobody likes me, and the people I hang out with aren't really my friends, they're just somebody to hang with, do some crack and have fun.*

Christine has refused to go to school and she is not really looking for a job either. She continues to run away regularly. *Yeah, what's the point of coming to school, I just gotta worry about moving, or something, if they're gonna keep moving me, I might as well stay home. Besides, I'm so far behind; it's stupid to go.*

When Christine was nine, she was found with two friends (ages 5 and 6), playing in the closet in the dark, without clothes on. The mother suspected inappropriate sexual activity and refused to allow Christine to play there anymore. The mother did not speak to Christine's mother, nor did she report to Social Services, although there are earlier reports on file of suspected inappropriate sexual activity in school. Christine claimed to have learned the 'games' from her father. Five years later, when she was 14, the children involved reported sexual abuse and there was an investigation. Christine was not charged because of her age at the time of the incident.

Christine's parents have refused to have her returned to their home. Her mother is frightened of the threats and they are no longer willing to

put up with the behaviour. She continues to run away. The social worker has just informed Christine that she will be seeking permanent guardianship order and Christine has asked for a foster home placement.

Analysis

Christine's ability to seek help and to survive to this point is the only protective factor in evidence. She has experienced repeated losses from an early age, both within her family and within the school system. Her most recent loss of family is relatively permanent and she seems to be seeking a way to replace that. Her early sexual abuse is unresolved and, rather than having her early sexual acting out identified and dealt with, she was re-victimized through the criminal investigation. Christine may well have an undiagnosed learning disability that has aggravated her school difficulties, and the impulsivity associated with ADD places her at great risk for attempting suicide. The child welfare system has added to her continuous loss experiences through the cycle of placements and returns to her family, all of which increase her risk for suicide. In her friends, Christine has continued the pattern of superficial relationships. There is also the additional risk associated with substance abuse. She needs a long term relationship with a counsellor, beginning with crisis intervention and contracting against suicide behaviours. Stability in her placement is essential and the foster parents will need to be prepared to support her through ongoing difficult behaviour and possible suicide attempts. They must be trained in suicide risk assessment and have good back up supports in place.

SUMMARY

As a practitioner, when you meet a youth, learn about the systems that he or she is part of. Learn about family, friends, school, church, and community and how the youth sees his or her relationships within those circles. Learn about the protective factors and the risk factors, consider the interaction between them, and make a mental note of the risk for suicide behaviour and the potential for additional losses, which might trigger a spiral into depression or cognitive confusion.

Build a relationship with the youth, but more importantly help the youth to build or maintain additional significant relationships with those already present in his or her life. The sense that no one cares is a critical loss for any youth and the feelings that someone cares AND needs to be cared about are important protective factors. Youth who have contemplated or attempted suicide, though, and emerged from the blackness describe the importance of that sense of relationship in their survival of the crisis (Stuart, 1999).

If you work with youth, the temporary state of a suicidal crisis may arise at any time. Being prepared to shift from the population perspective to the individual perspective is essential. Being comfortable accepting the

pain of a youth's life as real and creating a safe place to contain it will happen in the relationships that you have built over time.

EPILOGUE

Barb

Two years later, Barb is in grade 12 at the regular high school and has applied to university. She is graduating with her class, having made up the time in the alternative program. She continued with the counsellor, *Mom was very scared mostly, because she knew the signs of stuff like that. I talked to her for about a year, a year and a half. I was also on antidepressants. I think it was Prozac. I was on that for eight months or something like that. And then I decided I'm not going to take those anymore, I'm going to do this on my own. So, I started going to the gym a lot and doing aerobics and exercising.... And then I started getting closer with my mom, which also helped a lot.* Barb did attempt suicide. *But I'm not really proud of that. And a friend of mine had walked in when I was doing that, and she says what are you doing? I just broke down and started crying, and she was like what's wrong? Because no one knew, really. It took about two years from the final, you know, to stop what I was feeling.* She finds that March is still a difficult time for her, but has developed strategies for dealing with it. ... *the way I usually get around March, is making sure I go to the gym, and make sure I go to school, and I talk with my mom a lot. ...And another thing that I did is I forgave him, I didn't, I'm not going to hold him totally responsible for it. ...I'm not ever going to like not feel anger towards this person, but I forgive him for it and that's something else. It was a big help in my life anyways.* The black hole isn't gone completely, but she knows the signs. *I start feeling very low, like I don't want to get up, I don't want to do anything. I don't want to have any relationship with anyone really, maybe a couple of close friends. So that's when I start okay, let's calm down a bit here, what's going on. I can't always do it by myself. I need help.*

Christine

According to the Office of the Children's Commission (1998): *This youth in care had run away from a group home two days prior to this incident and was staying in a seventh floor apartment which was being rented by a 16 year old youth. At the time of this incident, the youth renting the apartment, and three other youths were in the apartment. This youth was wearing some clothes that she had borrowed two days previous from one of the youths at the apartment. An argument ensued in which the acquaintance demanded the immediate return of her clothes. According to the four witnesses, the youth made a comment which indicated she was very angry. She then walked over to the closed sliding balcony doors, opened them and scissored her legs one at a time over the railing. Two of the youths moved toward her and one youth grabbed at her clothing just as she let go. The youth was unable to hang on to her and she fell seven stories to the pavement below. Youths inside the apartment immediately called Emergency Health Services, as did another person who was outside the building and heard*

the sound of the youth hitting the pavement. Police arrived at the scene within three minutes and noted that the youth moved her head and arm, and made a noise. Emergency Health Services arrived seconds after the police and had the youth to the hospital approximately eight minutes after they arrived on scene. It is believed that the youth died enroute to hospital. The toxicology report on the youth was negative.

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