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NEW JERSEY OPINION;
SOME 'EXPERTS' ONLY OBSCURE PROBLEMS OF TEEN SUICIDE

BYLINE: By **MILLER NEWTON; Miller Newton,** Ph.D., is the president and clinical director of KIDS of Bergen County, a private, not-for-profit organization that diagnoses and treats adolescents with drug and alcohol problems.

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ROLAND CARTIER, age 13, committed **suicide** in Putnam, Conn., last summer.

His death triggered a town debate about the game Dungeons and Dragons and whether it should be played during free periods at school.

Opponents made a strong case that the game was responsible for the **suicide,** but Roland's friend Eric Bergeson blew that argument away. He said simply: "It was drugs."

This report in a New York Times article on Aug. 22, 1985, illustrates the problem of understanding **teen**-age **suicide** today. It has become a trendy item for mental-health types looking for a new key to prominence in their profession. Many people are running around as "experts on **teen**-age **suicide,**" creating more of a smoke screen than clarity about the issue.

There were 5,050 reported **suicides** of people between the ages of 11 and 24 in 1984. There probably were as many as 50 to 100 percent more, for we know that many accident victims are drug-using **teen**-age **suicides** who close their eyes on the handle of a motorcycle or behind the wheel of a car and play "chicken" with the school bus or the "semi" van.

Between 85 and 90 percent of adolescent **suicides** occur because the victim was a drug and alcohol user at the time of death.

I was giving an in-service workshop for school counselors and psychologists in a Dallas suburb at the end of the first major **teen**-age **suicide** "run" in the country (11 or 12 were reported in that town). As a result of questioning the counselors and psychologists from the school district where the **suicides** occurred, I became certain that all but one of those **teen**-age deaths were related to drugs and alcohol. School counselors had not thought to ask questions about drugs.

One "expert's" list of precipitating factors for **teen**-age **suicide** included: creativity and sensitivity, depression, presence of a chronic or debilitating illness, previous **suicide** attempts, family history of **suicide** or depression, hypochondric preoccupation and the use of drugs and alcohol.

In the view of this new breed of **teen**-age **suicide** experts, drugs and alcohol were the last on the list and probably the least important.

Alcohol/drug-use is often the undiscovered factor in a **teen suicide** only because no one asked.

When **teen**-agers begin to use drugs and alcohol in response to peer pressure, they go through a period of learning about the "high" and the effects of the drugs. This is usually experimental use with peers. At this point, no behavioral or affective consequences result.

When these **teen**-agers begin to enjoy the experience, they move on to the second stage of drug use. This involves actively going after the "high" - that is, taking control of their drug use and obtaining their own supply and the private space and time to get high.

At that point, modest behavioral changes occur that are hardly detectable from the erratic behaviors of adolescence. Some negative feelings begin because of loss of closeness to family. Hobbies, sports and activities are given up, as well as guilt from "doing" drugs, something they had not intended to do.

As the young person begins to use drugs to cope with bad feelings, the obsession with using drugs intensifies.

The third stage involves preoccupation with getting high as the center of one's life. At that point, behavioral problems break out all over the young person's life. There is trouble at home and stealing. The family arena becomes a battleground. The losses are substantial. In the affective domain, the young person begins to accumulate a mass of guilt over specific behaviors: lost hobbies, sports, productivity at school and career futures, lost closeness with family. There is guilt over doing drugs and guilt over immoral behaviors while under the influence of drugs.

The result is a free-floating mass of guilt that causes the **teen**-ager to try to cut down or quit using drugs. When the attempt fails, the guilt converts to a second feeling: shame, a generalized bad feeling about one's self.

"After all, if I did drugs, gave up important things, engaged in 'gross' behavior and couldn't quit, then not only am I doing bad things, but I must be no good, a defective human being, a piece of 'moral crap.' "

The result is the development of dull, painful feelings whenever the young person is not intoxicated or high. Very soon, the trap of feeling bad when not high, getting high to deal with the pain and then engaging in the behaviors that contribute to guilt and shame under the influence of drugs leads toward suicidal thinking.

"I'm a piece of crap! The world sucks! Why not go out in a blaze of glory by overdose like John Belushi!"

Kids often contemplate death by overdose, by automobile or motorcycle accident or even by more violent means. The implicit reason: "Then they'll really notice me and care."

There are certainly other causes for about 10 to 15 percent of teenage **suicides.**

Chronic depression, severe family problems, a major loss or other mental illness. Given the peer influence and suggestibility of adolescents, some of these **suicides** are triggered by previous peer **suicides;** hence the "run" of **suicides** in several communities.

The time has come for us to quit playing games with kids' lives and recognize the real causes.

Third- and fourth-stage drug-users are, in their pain, sitting targets for self-initiated death. And **suicide** is the second most frequent cause of **teen**-age deaths, accidents being first.

Current **suicide** prevention efforts often cause more problems rather than provide solutions.

One girl currently in treatment in my clinic became interested in **suicide** as a result of a preventive presentation on **teen**-age **suicide** in her school. She picked **suicide** as a way to get attention from her peers.

As the cry of "chicken" rang in her ears, she became increasingly obsessed with **suicide** as a way to convince her peers of her unique importance. After several **suicide** attempts, she ended up in treatment at KIDS of Bergen County, obsessed every waking moment with taking her own life.

I wonder about us adults who make professional hay without thinking of the effect on kids of our ill-conceived prevention efforts.

First, we must stop ill-conceived "trendy" **suicide** prevention programs that play into the "suggestibility factor." Next, we adults need to accept our responsibility for making adolescence a safe passage. "Rights" and "freedom" that give kids choices with lethal consequences are not acceptable.

Finally, we need to stop the insanity of adolescent alcohol and drug use, preventing kids from reaching weariness with life and despair where death is a welcome relief.

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TEEN-AGE SUICIDE: EPIDEMIC, NOT TRENDY

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In his Dec. 1 Opinion article, **Miller Newton** said that **teen**-age **suicide** had become a "trendy item for mental-health types looking for a new key to prominence in their profession."

Suicide is not trendy. It is an epidemic in this country, being the No. 2 killer of people between the ages of 15 and 24 (just behind automobile accidents).

Adolescent **suicide** has tripled since 1950; 6,500 young people a year now take their own lives. For every **suicide,** statistics tell us there are 50 to 100 attempts. That means **teen**-agers make 325,000 to 650,000 **suicide** attempts.

Next, Dr. **Newton** asserts, "many people are running around" as "experts on **teen**-age **suicide,** creating more of a smoke screen than clarity about the issue." He is uninformed about programs, such as the Adolescent **Suicide** Awareness Program operated by the South Bergen Mental Health Center Inc. in Bergen County, which are doing just the opposite.

A.S.A.P. provides the most current and accurate information to teachers, students and parents about adolescent **suicide.** It helps to dispel the myths, outlines warning signs, reviews the complex causes of adolescent self-destructive behavior, discusses how to help in an emotional crisis and identifies community resources and procedures to help the potentially suicidal individual.

It also develops effective communication and referral procedures between schools and community mental-health centers.

Dr. **Newton** then says that, in the view of "this new breed of **teen**-age **suicide** experts, drugs and alcohol were the last on the 'list' of causes of **teen**-age **suicide.**"

"Between 85 and 90 percent of adolescent **suicides,**" he says, "occur because the victim was a drug and alcohol user at the time of death."

What Dr. **Newton** fails to realize is that **suicide** is almost always an act in which alcohol and drugs can play a part, but are rarely the only cause. Family problems, interpersonal conflict, romantic relationships, social pressures, high expectations, psychological and physical illness - all could result in a **suicide** attempt.

Alcohol and drugs do play a part in **suicide,** and many individuals who are troubled and depressed turn to them as a form of anti-depressant. The problem is, however, that, once under the influence of such substances, some individuals lose their inhibitions, become desperate about solving their painful problems and then make an impulsive and all-too-often fatal **suicide** attempt.

There is no doubt that drugs, alcohol and **suicide** are a lethal mix; however, there is no evidence to confirm Dr. **Newton's** claim that alcohol and drugs are the cause behind adolescent **suicide** and that 85 to 90 percent of adolescents

who committed **suicide** were drug and alcohol users.

Next, Dr. **Newton** dictates: "We must stop ill-conceived, 'trendy' **suicide**-prevention programs that play into the 'suggestibility factor.' "

A.S.A.P. is anything but ill-conceived. The program was developed jointly by mental-health professionals and school staff, piloted at River Dell High School in Oradell and over a four-year period systematically introduced throughout Bergen County.

The program is currently being replicated by the five community mental-health centers in Bergen County and is available to all public, private, parochial and special-needs schools in the county.

Finally, Dr. **Newton** talks of suggestibility. He cites the case history of a young girl in his program who supposedly attempted **suicide** just because she attended a **suicide**-prevention workshop in her school. He seems to be saying that we should stop educating youngsters about the myths of **suicide,** recognizing the warning signs, drug and alcohol abuse and where and how to get help.

We might not be able to prevent all **suicides,** but we can prevent - and have prevented - many through such programs as A.S.A.P. Many presuicidal adolescents have directly been identified and referred for help through A.S.A.P.

Many **suicides** appear to be preventable. We can take effective action through such preventative programs as A.S.A.P.
DIANE M. RYERSON, Director, Adolescent **Suicide** Awareness Program, South Bergen Mental Health Center Inc.
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