CHAPTER 22

GROUP COUNSELING FOR SUICIDAL ADOLESCENTS

CHARLOTTE P. ROSS
JEROME A. MOTTO

The identification of adolescents at high risk for suicide presents us with the formidable challenge of providing effective intervention and treatment. Based on the apparent relationship of suicide in this age group to family instability, interpersonal stress and alientation, the Suicide Prevention and Crisis Center of San Mateo County, California, developed a group counseling program for suicidal adolescents designed to address these conflicts. Seventeen youngsters participated in the program, which included 35 group meetings over a period of 40 weeks and an ongoing individual relationship with a special staff member. Twelve girls and five boys took part, of whom 10 had attempted suicide (26 attempts among them) and seven had threatened suicide. The focus was on 1) providing a supplemental support system, 2) learning constructive ways of dealing with stress, 3) enhancing self-esteem, 4) learning supportive techniques ("befriending") and 5) developing effective means of coping with dysphoria.

The development and implementation of the program are detailed, including unanticipated problems, special measures used, and prominent themes in the group process. No suicides or subsequent suicide attempts were found among the 14 group members available for a two-year followup. Further exploration of this approach appears warranted.

Social and professional concerns about rising suicide rates in adolescents have led to a number of studies, focusing primarily on psychosocial antecedents and characteristics of young people who are likely to engage in suicidal acts. These investigative efforts tend to reaffirm the close relationship of family instability, interpersonal conflict and alienation to self-destructive behavior in this age group.[1–4]

Identification of those adolescents at high risk for suicide leads us to the challenging task of planning and carrying out an intervention program for them. The acceptance of professional help by a troubled teenager is a big step in suicide prevention efforts, but is often only the

beginning of a long and arduous task. The treatment of adolescents and their families is frequently difficult, and at times the situation may even be considered "unworkable" with available treatment methods. Even in the most resourceful settings, the outcomes can leave much to be desired.[5-6]

The Suicide Prevention and Crisis Center of San Mateo County began a special prevention and intervention program for suicidal adolescents in 1975, focusing on early detection using a health education approach in the public high schools.[7] This program resulted in a significant increase of requests to the Center for both consultation and direct services for suicidal teenagers. The number of adolescents contacting the Center rose from 8% to over 20% of the Center's client population. In seeking to meet the special clinical needs of these young people, we began exploring the feasibility of group counseling for suicidal adolescents.

The concept of group work with depressed and suicidal adults is not new,[8-11] and various types of therapy groups for adolescents have also been reported.[12-15] We were able to find only two reports, however, of adapting the special potentials of the group approach to the unique clinical demands of adolescents at high risk for self-destructive behavior.[16,17] No specific guidelines were provided for such an effort outside a hospital, however, and the feasibility of such a group in an outpatient setting remained to be established.

The thought of taking on six to eight high-risk adolescents at once was somewhat intimidating, but our positive experience with adults in the same setting[18] encouraged us to pursue the possibility. The present discussion details our preparation and clinical experience in this effort.

ORGANIZATION AND STRUCTURE

The Suicide Prevention and Crisis Center is a contract agency of the San Mateo County Department of Health. The County Adolescent Services Unit, an integral part of the community mental health system, offered to collaborate with the Center in developing and implementing a group counseling program for adolescents at high risk for suicide.

It was agreed that the directors of the two agencies would serve as consultants to the program, and that each agency would provide one group leader. Primary responsibility for the group was assigned to the leader provided by the Center, a marriage, family, and child therapist with 12 years experience as a high school teacher and counselor. The County Adolescent Unit provided, as the co-leader, a psychology intern with special interest and training in working with young people.

To supplement the planning, two outside consultants were used for a critical review of plans, methods and goals. One brought a background of theoretical and clinical interest in suicide prevention, and experience

with group therapy for high-risk adults (Jerome A. Motto, MD), and the other was a recognized leader in the theoretical and clinical aspects of group therapy (Irving Yalom, MD).

The goals of the group were to 1) provide a supplemental support network for its members, 2) help the participants learn strategies and skills for dealing with stress, 3) improve self-esteem, 4) learn supportive ("befriending") techniques, and 5) develop effective ways of handling dysphoria that would serve as alternatives to suicide.

The support network was planned to consist of the group leaders, the group members, and the Center's 24-hour crisis service, which offered both around-the-clock telephone and face-to-face "drop-in" services.

The original plan called for a "closed" group, with an unchanging set of members meeting for an hour and a half, 4:00 to 5:30 PM, weekly for 12 weeks. The meeting was subsequently advanced to 3:30 to 5:00 PM because the members preferred to come to the group directly from school. The duration of the group was also changed when some group members began expressing anxiety about the group ending at the 12th meeting. The group leaders shared some of this anxiety, and the decision was made to continue the group at least through the remainder of the school term. It was also decided that new members could be added as attrition allowed. The sessions were scheduled in a conference room in the same building that housed the Center, but not in the space occupied by it.

It should be emphasized that the group was designed to augment—not replace—other forms of therapy. Participants who were not in treatment when they entered the group were asked to see a therapist from the community health system, at least for an assessment interview, for the purpose of assigning a "therapist of record." The majority of members did this, but the resistance to it became so great that the idea was later abandoned.

In considering referrals to the group, an effort was made to accept any high-risk adolescent except those individuals whose symptoms indicated psychosis or violence, and those whose primary clinical problem was alcohol or drug abuse.

The name chosen for the group, "Peer Befriender Group," was derived from an earlier program developed by the Center, The Befrienders, which in turn was patterned after the long-established Samaritan organization based in Great Britain. In The Befrienders program, volunteers were assigned to "befriend" clients who might benefit from a supportive, goal-oriented relationship. Since a goal for the group was to help the members learn to befriend each other and themselves, the selection of this name seemed appropriate.

Formation of the Group

Candidates for the group were identified from three sources: the adolescent clients of the Center, referrals from high schools in the San

Mateo area, and Youth Service Bureaus. School referrals were generated by sending an information sheet about the project to the school nurses. This one-page description of the "Peer Befriender Group" invited referral of appropriate candidates of high school age to one of the group leaders.

The Center's background of prior collaboration with the school system facilitated referrals from school personnel. A high school "Suicide Prevention Education Program" had been carried out by the Center in the form of classroom discussions, followed by an offer of consultation for students about whom questions regarding suicide arose.[19] Thus, communication channels were already open between the Center and school personnel regarding any concerns the latter had about their students.

In addition, the group leader arranged to speak at a meeting of the San Mateo County school counselors and nurses to explain the program. She wanted them to meet her, ask questions, and discuss possible referrals and ways to facilitate offering the group to appropriate students.

Ongoing adolescent clients of the Center who were considered to be in need of additional support services were screened by the leaders and the Center director for admission to the group. Priority was given to those who seemed to be at greatest risk or in greatest need.

The invitation to join the group was presented by some variation of the following: "We are starting a support group for high school students who are depressed. It will be the sort of group in which members can learn that others may have similar problems, find ways to deal with their situation, and know where help is available. There is no fee charged for this group."

Additional information was provided in response to the youngsters' questions. The most frequently asked questions were:

Are you a teacher/nurse/counselor at my school? The concerns that lay behind this query were gently explored and found to deal with whether the group leader could influence the student's passing or failing, being transferred or having a notation of "unstable" entered in the school records.

The group leader did acknowledge that she was a teacher and a counselor, but made it very clear that her role with the group was a separate and different one. She explained that the group was a service offered by the Suicide Prevention and Crisis Center, and was not a part of the school system. From the adolescent's point of view, the group's separateness from the school was seen to be an asset, as it had no power or authority over its members, did not give homework, did not grade or discipline, and did not report to any other authority.

Who will know that I'm a member of the group—if I join it? Who will know what goes on in the group? This concern with confidentiality was a major and constant theme. The group leader assured them that their desire for privacy was understood and would be respected. She

pointed out that, having been a teacher for several years, she knew many students and people in the school system. However, she promised that if she were even to pass a group member on the street, she would not say hello or acknowledge knowing them in any way unless they indicated first that it was permissible. They expressed appreciation for this sensitivity to their social structure.

Is my family supposed to come to the meetings? Will my family know? Will they have to give permission? We learned that most of their experience with "helping" resources had been limited to services which were, by law or custom, responsible to their parents, eg, school counselors, nurses, county health agencies, or the juvenile justice system. In addition, the majority of these students described their families as resistant to mental health treatment. In some instances, they indicated that their families might approve of their participation, but would do so principally as verification that the child, rather than the parent, was the source of the problem. In other instances, the parent's resistance seemed to stem only from lack of information and it was felt there was good potential for improving communication and gaining family cooperation. Two youngsters indicated unwillingness to consider the group if it required any family involvement, and subsequently described home situations in which their families warned them not to discuss "family problems" (ie, parental alcohol/drug abuse, battering, or incest) with "outsiders."

The group leader explained that, while she would like very much to have their family involved, she would respect their judgment regarding the risks they felt existed. They were told that they were free to tell their families as much or as little as they wished about the group, and that we would encourage but not require communication with their families.

California law enables a minor who has attained the age of 12, as well as designated maturity and intellectual levels, to receive mental health treatment or counseling on an outpatient basis without the consent of a parent or guardian. The professional person providing such service has the psychotherapist-patient privilege as regards confidentiality.[20]

Are you a psychiatrist? Will I have to see a psychiatrist? The adolescent's fear of being different is well known, but these youngsters' fear of being very different or even "crazy" was compounded by a fear that others would discover their shameful secret, which added to their distrust. They were assured that being in pain was very different from being "crazy" and that we (and/or their teacher/counselor/nurse) were concerned about the pain they were feeling. The leaders explained that there were many ways to deal with pain and despair, that one of these ways was to talk with others who were suffering similar feelings, that it was possible to learn new ways to handle problems, and that the group was intended to be a learning experience, not a psychiatric treatment program.

Each explanation and each piece of information was seen as an opportunity to develop the student's trust and confidence in the group leaders. In addition, a key factor in gaining their acceptance was our willingness to go into their territory, rather than requiring them to come to ours. In arranging an evaluation interview, the leader asked each youngster where he or she would find it easiest to talk. Most often, they preferred meeting at their school, although sometimes they requested that the interview be held at a neighborhood coffee shop. Again, we found that sensitivity to their problems concerning transportation, schedules and privacy was important and appreciated.

Sixteen adolescents were invited in this way, of whom 10 expressed an interest in coming to the Center to discuss it further, and made an appointment to do so. All 10 kept their appointments, which consisted of informal one-hour interviews with the two group leaders to resolve any remaining questions as to the desirability of participating. Of the 10 candidates interviewed, eight accepted the invitation to join the group, and two were seen by the interviewers as better served by other resources since they were seriously involved with alcohol and drugs. Those who elected to take part were given the date, time and place of the first meeting.

Composition of the Group

The selection procedures described above resulted in eight adolescents, five girls and three boys, being chosen to start the group. Six had a history of prior suicide attempts, and two were severely depressed and threatening suicide. Four were from the pool of Center clients, three were referred from the schools, and one was from a Youth Service Bureau. One of the boys made a suicide attempt before the first meeting, and following hospitalization, was sent outside the state, reducing the initial group to seven. They can be briefly described as follows:

Aileen, age 17, had severe family problems and had been referred to as a "pathological liar." She stated "I can make myself and everyone else believe *anything*." She had taken overdoses of aspirin or alcohol and drugs six times, saying she was not really trying to kill herself, but was angry with herself and wanted to punish her body. Aileen was referred by her school.

Jane, age 15, was physically abused as a baby and still had the resulting scars on her body. She was adopted at age 3 by older parents who were very strict and "old-fashioned." During a period of depression, she took an overdose while at school and was hospitalized for two weeks. She was referred by the Center, where she had been a frequent caller.

Arthur, age 18, had problems with his family and his girlfriend. He had made a recent suicide attempt with carbon monoxide that led to a two-week psychiatric hospitalization, but continuing psychiatric help was cut short by lack of funds. He was referred by his school.

Elaine, age 15, had a history of sexual abuse from the age of 9 and she had an abortion at 13. Her mother was bisexual. Chronic truancy and three suicide attempts (all overdoses) led to her calling the Center frequently, in spite of being very withdrawn. She was referred by the Center.

Carol, age 17, was referred by her school because of severe depression. The youngest of seven children in a violent family with an alcoholic father, she could barely contain her anger and had, on several occasions, pounded her fist through a wall. She had taken an overdose twice and had been hospitalized once for psychiatric care.

Erik, age 14, had problems with his family and school and had been in Juvenile Hall and other detention facilities. His father drank heavily and Erik used both drugs and alcohol. After two group sessions, Erik was sent to another state to avoid further detention. He had been referred by the Center.

Betty, age 14, had problems at school and with her family. She had been in detention homes three times for running away, and had abused drugs. Her mother suffered from alcoholism. She was severely depressed, and had been a frequent caller to the Center, from which she was referred.

Subsequent selection procedures led to the addition of 10 more participants. Six of these joined the group at the 13th meeting, by which time attrition had reduced the original group to three members. One more member was added at the 16th, 17th, 22nd and 24th meetings. Of these new participants, five had a history of prior suicide attempts, one had threatened suicide, and four were seriously depressed. Two were from the pool of Center clients, six were referred from the schools, one by her mother, and one by a friend. They can be briefly described as follows:

Georgia, age 15, was a homosexual student with severe health problems. She was referred from her school. She had a history of early physical and sexual abuse, and had used alcohol and drugs. She had made six suicide attempts with pills and alcohol, and had one psychiatric hospitalization.

Diane, age 16, was referred by her school due to two suicide attempts by overdose. She came from a seriously disturbed family in which she had been the victim of sexual abuse, and was still torn between allegiance to her divorced parents. She lived with the family of a friend, and intermittently returned to her father who was using drugs heavily.

Charles, age 18, was referred by his school after he attempted suicide by crashing his car following a quarrel with his homosexual partner. He made excellent grades, but when his homosexuality surfaced, he began to use drugs heavily. Conflicts in the family, especially with his father, had been reflected earlier by persistent truancy.

Adam, age 18, was referred to the group by his mother. She was concerned because Adam had not worked since graduating from high school, and he was severely depressed. Sexual identity issues were present, and he was full of rage at his overprotective parents. Adam only came to the group one time and withdrew because the girls were "not interesting" and the boys had "other issues."

Wynette, age 15, came from a broken home in which the paternity of the two children was not clear. Her mother lived with many men and was a heavy user of drugs and alcohol. Her mother was 14 when Wynette was born, and reiterated that she was sorry she ever gave birth to her. Wynette had taken overdoses of drugs on two occasions, "hoping I would sleep and not wake up." She also had a history of truancy.

Wanda, age 13, lived with her divorced mother who was very career oriented. Wanda got attention by taking drugs and staying out overnight with a boyfriend. Her mother was unable to set firm limits. Wanda was referred by the Center, which Wanda had called in a depressed state, threatening suicide.

Matthew, age 16, came from a very strict Catholic family that felt it was being punished by having a son like Matthew. His father was an attorney and his mother was very active socially. Matthew got attention by using drugs, driving fast, burning himself, and being active sexually. He had been expelled from school and from a summer program, and was working at a gas station. He was referred by a friend.

Christine, age 15, was referred by her school after two overdoses and one hospitalization. Her mother, father and stepfather were alcoholic. She and her older sister had been sexually abused, and she was struggling to get along with her stepfather and to maintain peace in the home when her parents were drunk. She felt very unattractive, and was beginning to experiment with drugs so she could be more accepted.

Louise, age 16, Christine's sister, was sexually active and in conflict with her stepfather about restrictions on her behavior. She had previously been an excellent student, but her school work had deteriorated. She had not attempted suicide, but was depressed and acting out sexually. She was referred to the group by her school.

Clarice, age 14, lived with her mother and two younger sisters. She was often left to babysit for her siblings and felt resentful at all the time her mother spent away from home. She used drugs to relieve her feelings of alienation and depression, but had made no suicide attempts. She was referred by the Center.

Three youngsters, two boys and one girl, withdrew from the program after only one or two meetings, thus they were not able to make use of the ongoing group process. The number of participants who were finally included in the counseling program was, therefore, 14—11 females and 3 males.

A total of 35 group sessions were held over a period of 40 weeks. The average attendance was 5.5 (range 2–11), and the average number of sessions each adolescent attended was 13.4 (range 7–29) over a mean period of 19.5 weeks (range 8–40). These data are detailed in Table 22-1.

OBSERVATIONS ON THE GROUP PROCESS

The Early Group Meetings

The first meeting began by the leaders introducing and giving background information about themselves. Each offered brief statements regarding his/her personal life. Both focused their comments on their involvement with adolescents, and their choice to work with youth because they liked and valued such relationships and experiences.

Table 22-1
Summary of Group Participation

Name	Age	No. of First Session Attended	No. of Sessions	Duration of Participation (Weeks)
Arthur	18	1	10	12
Aileen	17	1	10	9
Betty	14	1	19	18
Carol	17	1	29	40
Elaine	15	2	10	11
Jane	15	3	25	31
Erik	14	3	2*	1*
Louise	16	13	7	13
Georgia	15	13	15	28
Christine	15	13	17	28
Adam	18	13	1*	1*
Charles	18	13	15	28
Diane	16	13	7	8
Wanda	13	16	8	17
Wynette	15	17	8	13
Clarice	14	22	1*	1*
Matthew	16	24	8	17
Total			188	273
Mean			13.4	19.5

*Not included in totals or means.

The leaders next spoke of "rules," specifically, 1) being on time, 2) letting the leaders know if they would be unable to attend, 3) not smoking in the meeting room, 4) not using drugs or alcohol when attending group, and 5) protecting confidentiality. These were presented as issues of consideration and caring about each other and themselves, ie, not keeping others waiting or wondering, not polluting others' air, giving their full attention (nondrugged) in the meetings, and respecting each others' confidences by establishing trust and reliability. Thus, the rules were presented simply as "fair" ways of treating each other and themselves. All agreed to their appropriateness and to abide by them.

As a means of getting started, all the participants were asked to play the Name Game, which involved telling their name, where it came from, and how they felt about it. This provided the opportunity for members to begin talking about themselves and their families, to express some feelings, and to indicate their preference about their names or nicknames.

There was a lot of shyness in the beginning. Carol spoke of feeling shy in groups, avoiding dating, and sometimes putting people down as a way of distancing. Betty said very little and looked at the floor much of the time. Arthur spoke of moving back to live with his father and stepmother, but did not mention his recent suicide attempt or hospitalization. Aileen mentioned relatives she felt close to who lived in the midwest. Generally, during the process of getting to know each other, the participants stayed on safe ground.

The last point before breaking up was to emphasize the importance of communication, and the suggestion was made that members call the leaders or the Center if any need arose. To facilitate this, the leaders provided cards with their home telephone numbers.

In the second meeting, the group got off to a more dramatic start. Arthur had attempted suicide the day before the meeting by slashing his abdomen, and was hospitalized. Upon learning of this, the group leader had visited him at the hospital. She asked what he wanted her to tell the group. His immediate response was, "Anything you want," but after he talked about what had occurred (a fight with and rejection by his girl friend, and learning of an uncle's suicide), he asked that she explain it to the group just as it had happened.

The group members expressed shock, concern, curiosity, and caring. After the meeting, Aileen, Betty and Carol each asked if it would be permissible to visit Arthur in the hospital, and each did so. Aileen took flowers. Carol went to a great deal of trouble to get there, traveling an hour by bus.

Jane, who had missed the first meeting, did not appear at the second meeting either, and the group was told the reason: she was also in a hospital, after taking an overdose of drugs. The leader reported she had

spoken to Jane and her physician, and Jane had asked permission to attend the group the following week.

These attempts brought the suicide issue clearly before the group. The reality of each member's thoughts and the consequences of their actions could not be avoided. It was sobering and frightening. Their reaction appeared to be to pull together, as each seemed to try to say to the other—wait, don't do that; it's not worth it.

Carol's "running away from home" to a girlfriend's house, which was discussed at length by the group, seemed almost mundane in the setting of the two suicidal actions. No effort was made by the group leaders to relate these acting-out episodes to starting the group counseling program, though much could be said about perceived expectations, low self-image and testing behavior. The subject was explored at some length by the staff outside the group, but no interpretations were suggested to the group itself.

At the third meeting, Arthur obtained permission from his doctor to come from the hospital to join the group (the Center is located in an annex to the hospital). Arthur spoke of how much the visits and phone calls from the group members had meant to him. In one call from Aileen, she had told him that she had taken an overdose of aspirin and was feeling sick. He immediately had the hospital crisis team and the Suicide Prevention Center contact her and make sure she was all right. Discussion of this in the group was dominated by Arthur's anger at Aileen, and at any group member who was so "stupid" and "selfish" as to attempt suicide instead of calling the group leader or other members to talk to them about their feelings.

The group leader drew out the feelings of being criticized and hurt that these comments evoked, and the group members were quick to assure Aileen that it was caring and not criticism they were trying to express. One said tearfully how sad and angry she would be if anyone in the group "really did it." This led to a discussion of how painful it is to lose someone important to you, like a best friend or a favorite uncle. It also led to a discussion of other sources of anger, such as parental discord, drinking, and excessive demands.

As members mentioned their families, they began to speak of sources of tension, especially parental behaviors, disciplinary methods, expectations from parents and teachers, and sibling conflicts. They also began expressing needs—the need for more unstructured time for themselves, male/female needs for recognition, and acceptance of their sexuality.

At the end of this session, telephone numbers were exchanged by all members of the group. Phone calls were eagerly solicited and promised in order to help a beleaguered member get through the weekend, if that became necessary.

The Adolescents' Befrienders

The enormous needs of these youngsters became painfully apparent within the first few weeks. They immediately began to turn to each other for support and, in addition, made frequent use of the Center's 24-hour telephone service. Their primary resources, however, were the group leaders, whom the youngsters called apparently at every critical point in their crisis-filled lives. Our concern that the members' needs for companionship, guidance, comfort and "rescuing" would exhaust the group leaders led us to seek an additional level of support for them. Thus was born the Adolescents' Befrienders.

We reasoned that to create what these youngsters most seemed to need and to be asking for, we would need to provide each member with a "therapeutic friend" on whom he or she could lean during a period of stress. It would be someone who understood the issues with which they were trying to deal, could support their positive efforts toward growth, and could serve as a role model. This description was not dissimilar to that of the Center's "Befrienders," the group of volunteers who gave large amounts of time to "befriend" and to work with individuals toward achieving specific goals and areas of growth.

From among the Center's volunteers, six people were selected on the basis of personality, attitudes, age, sex, and appropriateness as a "match" for the needs of each youngster. These volunteer Befrienders were required to make themselves available for personal contact several hours a week and whenever possible by telephone. In addition, they were to attend a supplemental three-hour training class to prepare them for their task, and then regular weekly staff meetings for ongoing supervision.

The first two Befrienders selected, a 20-year-old male and a 19-year-old female—both college students—were introduced to Arthur and Aileen just prior to the fourth group meeting. At that meeting, other members were asked if they would like to meet Befrienders. All said they would, and the "matching" proceeded over the next few weeks.

Four of the six Befrienders were young (19 to 24), and assumed the role of surrogate big brother or sister. The other two were a graduate student in her early 30s, and a professional woman in her 40s.

The Befrienders quickly became a significant part of the group experience. It appeared that the group had become a "family," and the Befrienders had extended the family to include that special person from whom each could seek advice, and whose behavior could be closely observed for alternative ways of relating to others. This extension of resources for the group members was particularly important because of the critical role that losses of significant persons had played in each member's life. It was inevitable that further losses would occur during the group experience; indeed, the group itself would eventually end.

Although time limitations were very real, the potential for providing a model for identification through the Befriender part of the program seemed essential. Even if it went no further than preparing for loss, coping with loss, and reordering one's life after a loss, it could provide the youngsters in the program with a source of strength, however modest, for many losses still to come.

Group Themes.

The first three sessions introduced the primary themes that were to engage the group over the ensuing nine months: family relationships, peer relationships, loss–grief–pain, anger, suicidal impulses, and what to do when these are experienced as overwhelming.

Family relationships, and the absence of family relationships, provided the bulk of the material for discussion, as every group member shared a need to resolve conflicts in this area. Every possible conflict seemed to surface: parental expectations and demands, parental alcoholism and depression, parental child abuse and incest. There was too strict limit-setting ("No matter what I want to do, my father says, 'No'") and not enough limit setting ("I can do anything I want and she doesn't say anything"). There were struggles to get away from the parents ("I just want out!") and strivings to find "real" biological parents, after a series of foster parents ("My foster parents are going to help me find my real parents!" Rejoinder: "I've never seen my real father, but I met my mother once, and I hope I never see her again"). Perceived role reversal was also a recurrent source of family stress ("I want to leave, but then Mom would have nobody to take care of her").

The theme of peer relationships centered around issues of dating, what thoughts one person had about another, the pain of perceiving others' thoughts about the self as negative, and the disbelief of perceiving them as positive. The group members were quick to support or to reassure each other as the situation required, without much weighing of all the elements involved. There was intensified discussion of boy-girl relationships when Christine and Matthew began to come early to see each other before the group met, held hands during the group meeting, and arranged to get together at a vacation area where both families were going in the summer. This precipitated some antagonistic comments from Carol about "not trusting men," and extended discussions about boyfriends and their vagaries, especially if they used alcohol. It also provided an opportunity to discuss the good feeling of a "natural high" when the euphoric mood of Christine and Matthew led them to laugh and giggle inappropriately when group members were speaking of serious issues. The resentment of feeling "laughed at" by the offending couple

was settled with appropriate apologies. Christine apparently wanted to keep the good will of the group, but seemed to find it difficult to empathize when she felt so fortunate to have Matthew as her "first real boyfriend."

The theme of boyfriends was tied to anxiety about losing peer relationships, and how painful it was when that happened. The problem of coping with that pain absorbed the attention of the group repeatedly, extending to the loss of family members, and even of pets. In one situation (at the 32nd session), the insistence of her foster parents that Jane give up a pet dog precipitated a serious suicidal episode. She tried to use alcohol to ease the pain, but it did not help. Feelings were stirred of not being "any good at anything," of being "unrecognized," and "unwanted," and a five-page suicide note said that she felt "her heart had been cut out" when the dog was taken to the Humane Society. She "saw no reason to go on living." The group leader arranged for her to be in a protected setting for a time, and the group came up with a plan to find a good home for the pet. The crisis gradually subsided without suicidal behavior, but a good deal of group time and energy was absorbed by it.

The theme of suicide was accepted as the kind of impulse that arises when you hurt badly. So many experiences proved to be a source of hurt that the specter of self-destructiveness was never very far away, though a number of meetings went by without explicit mention of it. The content was more on recounting the means of fending it off—using alcohol or drugs, running away, arguing with key persons, getting help from the group leaders, other group members, or from a Befriender.

Though despondency was made evident in many ways, anger was the predominant affect expressed verbally, playing some part in essentially every situation that touched these youngsters' lives. Thus, the persistent themes of loss, pain and self-destructive impulses were consistently intertwined with manifestations of anger as well, usually in the form of defiance of parent figures, school personnel, or employers.

The major theme of the counseling effort was the acknowledgment and acceptance of these feelings, and what to do when they threatened to overwhelm the person experiencing them. The essence of the communication was, first, there are people who care, second, this is who they are, third, this is how to get in touch with them, fourth and most important, if you give them a chance to express their caring, they can help you. The help may be simply in listening, understanding and providing emotional support, or it may be in any number of more active ways that will ultimately lead to a lessening of the pain of the experience. The most encouraging aspect of the group counseling project was that both the Center staff and the young people in the group became increasingly aware that these simple principles seemed to work in practice.

Group Characteristics

It must be asked how this group differs from those composed of suicidal adults and from other adolescent counseling groups. Though adolescents are unique in their individual characteristics, a few generalizations were suggested by this experience.

A striking issue was the degree of need these youngsters brought to the group. This need was not only for emotional support to help cope with self-destructive impulses, but evident in practically all aspects of their lives. As the themes noted above suggest, the family turmoil, peer pressures, and demands of parents or parent figures, jobs, school and internal needs, in combination posed a formidable challenge. Even the numerous crisis and decisions of everyday living (eg, transportation, temporary shelter) were brought to the group and group leaders in such abundance that exhaustion appeared inevitable unless the support system was increased beyond that ordinarily provided in group work with either adolescents or adults.

A second characteristic, closely related to the sustained high level of need, was the intensity of feeling that was generated by stress situations. This is a well-recognized characteristic of the adolescent period that has made helping efforts for this age group a difficult task whatever modality is offered. With youngsters who turn to suicidal behavior when in despair, the extreme emotionality demonstrated in the group setting poses a very special concern. For example when Jane had to relinquish her pet dog, it was an anguish that she seemed unable to bear without help from all the elements in the support system. Similarly, when Arthur was vehemently critical of Aileen for taking an overdose of aspirin, he seemed unaware of the ludicrousness of doing so from the hospital where he had been admitted for a serious suicide attempt of his own.

A third characteristic of the group was its high level of communication among group members, between individual members and the elements of the support system, and among the supporting elements. Thus, a telephone call from one member to another might result in a serious problem being made known to the second person's Befriender, who would call the Befriender of the member in trouble, who in turn would call that member and also let the group leader know of the situation. The group leader might invite the individual to share the matter with the group at the next meeting, though she usually let the group member decide the time and extent of engaging the group in the problem. There tended to be so intense a feeling of cohesion in the group atmosphere, especially when a member was in a crisis, that the usual adolescent concern for confidentiality did not seem to be an issue. It was as though a message to anyone in the system was a message to the entire system.

Even after one member (Betty) moved to another state, letters were exchanged with others in the group, who then shared the interchange at the next meeting.

This communicative openness apparently had only one condition: the person should mean what he or she said. As long as that requirement was fulfilled, no matter how distorted or exaggerated the content, immediate support and emotional strokes were forthcoming from the other group members. It seemed as though a need to be needed and to be a source of help vitiated any need for critical listening and careful weighing of the different sides of the issue. Empathic responses were unreserved and undiscriminating. The practical problems involved were left largely to the group leaders; the peer group was thus quite predictable and dependable as an ally of any member in a crisis situation. This differs markedly from what so often occurs in traditional group settings, in which a serious suicidal state in one member tends to result in the other members becoming acutely anxious, and drawing away from the one in crisis.

When the condition of honesty was not fulfilled, the group could feel so offended and betrayed that hostility and rejection would be triggered just as uncritically as support was offered under the usual circumstances. Thus, when it was learned, in the course of trying to find help for one member (Elaine), that the member had given a false age and had concealed information about her earlier contacts with the health system, the group was unequivocal in expressing its rejection. Even the group leaders were unable to find reason to protect Elaine from the group's feeling that it had been "conned," and they arranged for her referral back to her prior therapist. It is pertinent here that the group had responded with a great deal of feeling to Elaine's life experiences, which were particularly painful and touching. Having evoked this very intense emotional response, Elaine was felt by the group to have used them and their feelings dishonestly, and there was little evidence of understanding or compassion on the part of the group for her having done so.

Issues of sexuality were not prominent in the group setting, though this was recognized by the group leaders as an important developmental issue. Two group members spoke openly about sexual matters, but not in the context of conflict. One (Georgia) was lesbian, and spoke freely of her difficulties and disappointments with her sexual partners. The other (Wynette), in the context of seeking a definition for "genuine feelings of love," spoke of the sounds she overheard when her mother was with various boyfriends. Though some discussion of sexuality ensued, the group seemed uncomfortable with the topic, with some clear embarrassment when sexual activity was discussed openly, and the subject was not explored in depth.

In view of the frequency of incest and of conflict with parents regarding sexual activity, this seemed surprising at first. Resentment about limits being placed on their own sexual behavior shared the broader theme of "problem parents" and conflicts around discipline. The issue of incest, however, was clearly taboo. The five group members with such experience were reluctant to discuss it in the group, or allow the group leader to explore it. In individual discussions, it became clear that they saw themselves as different from everyone else because of their experience, that their self-esteem was greatly diminished by it, and that the powerful emotional block to exposure was intensified even more by the presence of males in the group. In most instances, the history of incest was not realized until the youngsters gradually let it be known to the group leader after several weeks or months of group participation. The need for a special group to deal with this subject led to the subsequent development of a Family Stress Service at the Center, which collaborated with the County Children's Protective Services in appropriate cases.

School activity was also an important issue that received relatively little time in the group. Its significance as a source of stress was clear in some instances, but the most prominent role of the school seemed to be as an instrument for the expression of anger and independent striving. Truancy or inadequate effort in the schoolroom were means of punishing a parent, asserting autonomy, or simply a means of withdrawing from a painful situation, akin to running away from home. Support was given for the idea of doing well in school, but the issue did not demand a significant amount of group time or energy.

Direct encouragement to take constructive action in various situations was provided, usually as a way to stimulate learning new coping methods. For example, when Matthew expressed reluctance to participate in family therapy, Georgia spoke convincingly about how helpful it had been for her, and Matthew was persuaded to try it. On another occasion, when Carol stated that an attractive boy's interest in her could not be due to any attractiveness on her part, the group reassured her that she was indeed a pretty girl, and encouraged her to accept that as a basis for handling the relationship. When Matthew was doubtful of the value of using a punching bag as a way of getting hostile feelings out, Christine was able to get him to accept one simply by her persistent encouragement that he do so.

The strong nurturing personality and highly involved, maternal style of the primary group leader had an enormous impact on the group. From the first session, she demonstrated that her involvement was not limited to the one and a half hours of the group meeting, and her support was not limited to merely discussing their problems. Members began "testing" her commitment from the outset, and continued to do so

repeatedly throughout the program by calling for help at all hours of the day and night. Some of the active interventions undertaken by the group leader in response to such calls were:

- Immediately going to visit members of the group who were hospitalized.
- Going out at midnight to pick up and take home a group member who left home after being beaten by her brother; notifying police of her action, and providing shelter for three days for a cooling off period for the family.
- Providing cautious support for Jane in her search to find her biological parents; helping with placement in a temporary foster home, and subsequently with placement in a group home.
- Meeting with the California Youth Authority to explore options and negotiate actions for Betty that would be in her best interest.
- Accompanying Georgia to the police department to report rape, and to the hospital for a physical examination.

TERMINATION

The 12-week prearranged time limit for the group had been set in order to avoid asking the youngsters for a commitment of time which would appear to be either vague or excessive. Although this limited commitment may have been appealing to the youngsters when considering entering the group, it became a source of anxiety when considering leaving it. As members began to express their concerns ("I don't know what I'll do when I can't come to group anymore"), Center staff explored ways to deal with their anxiety. Although the befrienders were seen as an aid in bridging the stress of the termination process, it appeared that the group needed more time. All staff members were aware of the association of attempted suicide with the termination of a supportive and meaningful relationship, and the need for a gradual transition to a modified support system.

Both the group leader and co-leader were scheduled to leave the area within two months following the originally planned termination date. It was decided that new leaders would be brought into the group and that the departing leaders' remaining time would be used for a period of transition. The group could then continue at least through the end of the school term. The transition period also involved a number of external changes for the group—the ending of the school year, the demands of summer jobs, and "enforced" vacations (two members were sent to spend the summer with a divorced parent living in another area).

Another factor affecting the termination of the group was the different style and personality of the new group leader. The original leader took a very active role, as described above, becoming deeply involved with each member. She dispensed encouragement, support and firmness with a confidence and vitality that commanded trust and tended to rivet the group into a close unit. The style of the new leader was more introspective, and her caring was expressed in a less active way. Her ability to elicit feelings, and to encourage expression of them, was geared more toward developing individual growth and problem solving than in furthering strong group ties.

Consequently, as the time for ending the group again approached, and the issue of termination was again raised, the members appeared ready to deal with it. Their feelings of apprehension about "making it" were intermingled with increased confidence in their ability to use what they had learned "on the outside."

It has been stated that, "if the therapist has done his job properly, the patient no longer needs him and breaks all contact."[21] This appears to be an admirable goal, indeed, but it was not seen as appropriate to our group. Members were encouraged to continue contact with the Center, and were assured that future requests for help—or just someone to talk to—would not indicate failure on their part, but would demonstrate taking good care of oneself.

FOLLOWUP

Followup calls two years after termination of the group provided information about all but three of the group members (Table 22-2), two of whom (Betty and Clarice) had moved away, and one (Elaine) could not be located. No suicides or subsequent suicide attempts were reported to the followup interviewer.

Two members had brief psychiatric hospitalizations. Louise reported that she had been a patient on a psychiatric inpatient unit, and then had lived in a half-way house for six months. At followup she had been seeing a psychiatrist on an outpatient basis for the prior six months, but "can't open up to her because she (the therapist) is not emotionally involved." Louise asked if she could come back into the group.

Jane was placed in a group home shortly after the group ended. She did well there, "graduated," and moved to a group home for older girls. This move precipitated a severe depression and she was again hospitalized. At followup she was living with a foster family, would soon graduate from high school, and was looking forward to college. She had kept in touch with the Center and referred to Center staff as her "real" family.

Table 22-2
Followup Status of Group Members after Two Years

	In School		Has Job		Lives with Parents		In Treatment		Overall Status			
Name	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Improved*	*Same*	*Variable*	*Worse*
Arthur		X	X		X			X	X			
Aileen	X		X		X			X	X			
Betty	living in another state											
Carol		X		X	X			X				X
Elaine	unable to locate											
Jane	X			X		X		X			X	
Erik	X			X	X			X		X		
Louise	X			X	X		X					X
Georgia	X			X	X		X		X			
Christine	X		X		X			X	X			
Adam		X		X	X			X		X		
Charles		X	X			X	X		X			
Diane	X		X		X			X	X			
Wanda	X		X		X			X	X			
Wynette		X	X			X		X		X		
Clarice	living in another state											
Matthew		X	X			X		X	X			

Adam, who attended only one meeting, and Erik, who was sent away after his second meeting, were found to have problems similar to those that originally brought them to the group. Adam's mother reported that he had again lost his job and spent most of his time on the streets. Erik was again having difficulty getting along with his parents.

Carol spoke sadly of the many difficulties she had faced since the group. She had been abandoned by her boyfriend, had an abortion, and a friend of 11 years had recently died. She did not have a job and was living at home. She quoted the group leader as having once told her that she was "too strong to commit suicide," and said she often repeated this to herself in order to keep going. She added that the group had enabled her to survive a very difficult time in her life, and expressed a wish to talk to the group leader again.

Arthur reported he was working as a house painter and "doing great." He said he had not suffered any further bouts of depression and had sought no other therapy.

Aileen stated that she was attending a community college and holding three part-time jobs. She added that she would like to be in a group again, if she "could be of further help to the members."

Christine, now a high school senior, was working as a salesgirl. She reported that things were "O.K." with her and she did not need or want any further counseling. She added that she had made friends at school, her life was busy, and she felt she was handling things satisfactorily.

Georgia stated that she was still seeing her therapist, and "everything is going well."

Charles was trying to start a gardening business, and reported that "starting a business is rough," but he did not get depressed as he had before. Following the group, he had continued in individual therapy with the co-leader through a county program.

Diane reported that she was "doing fantastic." She graduated from high school, was attending a community college, and working in sales. She was still living with her father, who had developed an appropriate relationship with her. She commented that the group was a "wonderful experience" and had enabled her to survive a "horrible time" of her life. She added that she missed the group leader.

Wanda was a high school junior, working as assistant manager of a telephone answering service. She was very proud of earning an impressive salary. She reported that she still saw her Befriender, talked to her at least two times a week, and referred to her as her "best friend in the whole world." She stated "I'm really doing great now."

Wynette dropped out of school after completing the 11th grade. She obtained a job, moved in with a girlfriend, and decided that she would not return to live with either her mother or father, who battled continually over her custody.

Matthew joined the army shortly after the group ended. His mother reported that he seemed to be doing well, and added that nothing else had reached or influenced him in the positive way the group had.

DISCUSSION

The essence of group counseling may be seen as the creation of a supplemental or substitute family designed to facilitate growth. For suicidal adolescents, that process involves primarily two tasks: The gratification of extreme dependent needs while supporting realistic independent strivings, and the nurturing of a healthy and realistic sense of self, or identity. Group work with nonsuicidal adolescents differs primarily in the amount of energy, disruption and social concern that are associated with self-destructive behavior.

A suicidal state is considered by some to be a contraindication to group therapy,[22] but this cannot apply when reduction of the impulse toward self-destruction is a primary goal in the formation of the group, and coping with that impulse is a powerful element in group unity and cohesiveness. The structure of a family-like resource for this task has enormous demands put on it. The first task is to understand earlier life experience, how family and peer patterns are perceived by the adolescent, and how the resulting stresses are defended against by self-destructive actions. The second, and most demanding task is to persevere in standing by the youngster supportively while encouraging a more constructive way of handling painful feelings.

The process of carrying out such an effort with troubled adolescents is an exacting task, even without the presence of suicidal states. Bates[23] points out the need to be prepared for unexpected confrontation at any time, and observes further how inexperienced group counselors may at first be naively confident, on the basis of their individual counseling skills, but that "it requires only a few grueling sessions to raise their panic level to the red button stage."

It seems clear that adolescents are more responsive to an "active relatedness" on the part of group leaders than to an introspective style. Ott et al[17] found themselves using a number of structured activities, such as pictures or stories, to stimulate active interchange in the group. They attributed the inertia problem to the overwhelming depressive state of the participants, as well as to their age.

When undertaken in a hospital setting, structuring a support system is made easier by the staff members' proximity and accessibility. For example, Ott et al[17] were able to provide a combination of individual evaluation, family therapy, psychodrama using puppets, milieu therapy, social education, and group therapy with nine suicidal adolescents on a

neuropsychiatric ward. The group sessions were considered the nucleus of the treatment program. After a four-month period of this multidimensional approach, they observed improved social adaptation, and 18 months after discharge reported the participants doing satisfactorily in school or at work, and with no further suicide attempts.

In an outpatient setting, caring adults whom the adolescent trusts and can reach at any hour are more difficult to provide. Our initial assumption—that the group members, group leaders, around-the-clock telephone crisis service, and individual counselors would suffice—proved incorrect, and necessitated the addition of the Befrienders. That these were trained volunteers suggests that, given current resources, perhaps only through collaboration with volunteer agencies can an adequate support system for suicidal adolescents be achieved for outpatient groups.

Though difficult to assess, the peer support system provided by the group deserves attention. During group meetings, it appeared to have a clearly positive effect. Outside the group, much undoubtedly transpired which was not reported in the group. In spite of this, we feel that the very presence of the peer network exerted a supportive influence, and probably reduced the demands placed on the group leaders and the Center. Though group workers have tended to take a negative view of outside contacts between group members,[21] in this setting we see it as a necessary and valuable resource. A program established for suicidal adolescents in Krakow and Lublin, Poland, focuses largely on the stabilizing influence of social interaction between the participating young people, their friends and families. In this multifaceted program, the "Social Club" is a synonym for the "Suicide Prevention Center."[24]

The only previous report of an outpatient group specifically for suicidal adolescents, to our knowledge, is that of Hadlik.[16] It was carried out in Brno, Czechoslovakia, in response to an increasing suicide rate in this age group. Hadlik cites "adolescent emotionality" as a characteristic requiring a special approach, noting that young people form groups more easily than adults, and participate more actively and spontaneously. He observed five prominent patterns in the group process: 1) by recognizing that their problems were the same as others, the youngsters' self-confidence increased, and by discussing those problems, they achieved a better understanding of their parents' and their own behavior, 2) a tendency of some adolescents to model their behavior after that of other group members, 3) maximum group communication stabilized self-confidence, 4) sympathetic support was elicited from other group members, and 5) through the process of being helped, motivation to help others was generated.

An initial plan that could not be carried through was to obtain serial ratings on a scale measuring suicidal potential, and on the self-administered Rosenberg Self-Image Questionnaire. Though theoretically

and methodologically indicated, the consensus was that the clear advantages of such a testing program were outweighed by the risk of alienating the participants before the group counseling program was even underway.

CONCLUSIONS

Group counseling for suicidal adolescents is seen to be a feasible program in an outpatient setting. In the project discussed here, the experience, knowledge, skill and dedication of the group leader were recognized as key elements in the group's development.

The critical factors in the group process appeared to be the understanding and involvement of staff members, and the subsequent facilitation of communication in the group. The group members gradually came to speak of their own painful feelings as well as express supportive responses to the anger, guilt and despair of the others. A sense of connectedness akin to a feeling of "family" gradually developed, which provided a safe setting to share feelings, to seek refuge in the group's caring and support, and to reach out to help others.

There is a great need for trials of group counseling for suicidal young people in various clinical settings, mindful of the unique strengths inherent in the group structure as well as its requirements for back-up support. It can be of special value in those instances when the young person has no family available or the nature of the family interaction precludes it having a supportive role. Though current practice puts much emphasis on family therapy as an essential part of an adolescent's treatment program, in those situations in which that is not feasible, we should not be dissuaded from offering the best substitute we have.

Lastly, in the face of our increasing problem of suicide in youth, group therapy for suicidal adolescents can be considered a promising supplement to the traditional treatment modalities of individual therapy and family therapy. Ever-present peer support can provide a stabilizing mechanism that goes beyond the usual counseling relationship, and can help make it possible for the traditional modalities to proceed more effectively.

REFERENCES

1. Berman A, Cohen-Sandler R: Suicidal behavior in childhood and early adolescence. Paper presented at 13th Annual Meeting of the American Association of Suicidology, Nashville, TN, 1980.
2. Tishler C, McKenry P, Morgan K: Adolescent suicide attempts: Some significant factors. *Suicide Life Threat Behav* 1981;11:86–92.
3. Shaffer D: Diagnostic consideration in suicidal behavior in children and adolescents. *J Am Acad Child Psychiatry* 1982;21:414–416.
4. Topol P, Reznikoff M: Perceived peer and family relationships, hopelessness and locus of control as factors in adolescent suicide attempts. *Suicide Life Threat Behav* 1982;12:141–150.
5. Meeks J: *The Fragile Alliance*. Baltimore, MD, Williams & Wilkins, 1971.
6. Stone M: The parental factor in adolescent suicide. *Int J Child Psychother* 1973;2:163–201.
7. Ross C: Mobilizing schools for suicide prevention. *Suicide Life Threat Behav* 1980;10:239–243.
8. Farberow N: Vital process in suicide prevention: Group psychotherapy as a community of concern. *Life Threat Behav* 1972;2:239–251
9. Motto J, Stein E: A group approach to guilt in depressed and suicidal patients. *J Religion Health* 1973;12:278–285.
10. Billings J, Rosen D, Asimos C, Motto J: Observations on long-term group psychotherapy with suicidal and depressed persons. *Life Threat Behav* 1974; 4:160–170.
11. Asimos C: Dynamic problem-solving in a group for suicidal persons. *Int J Group Psychother* 1979;29:109–114.
12. Westman J: Group psychotherapy with hospitalized delinquent adolescents. *Int J Group Psychother* 1961;11:410–418.
13. Kaufman P, Deutsch A: Group therapy for pregnant unwed adolescents in the prenatal clinic of a general hospital. *Int J Group Psychother* 1967;17: 309–320.
14. Bratter T: Group therapy with affluent, alienated, adolescent drug users. *Psychother Theory Res Pract* 1972;9:308–313.
15. Berkovitz I (ed): *Adolescents Grow in Groups*. New York, Brunner/Mazel, 1975.
16. Hadlik J: Group psychotherapy for adolescents following a suicide attempt, in Fox R (ed): *Proceedings of the International Congress for Suicide Prevention*, London, 1969. Vienna, International Association for Suicide Prevention 1970, pp 57–59.
17. Ott J, Guyer M, Schneemann K: Multidimensional clinical psychotherapy of a group of children and adolescents after attempted suicide. *Psychiatr Neurol Med Psychol (Leipz)* 1972;24:104–110 (in German).
18. Frey D, Motto J, Ritholz M: Group therapy for persons at risk for suicide: An evaluation using the intensive design. *Psychother Theory Res Pract* (in press).
19. Ross C: Teaching children the facts of life and death, in Peck M, Litman R, Farberow N (eds): *Youth Suicide*. New York, Springer (in press).
20. California Civil Code, Section 25.9; California Evidence Code, Section 1014.5.
21. Yalom I: *The Theory and Practice of Group Psychotherapy*. New York, Basic Books, 1975.

22. Horwitz L: Indications and contraindications for group psychotherapy. *Bull Menninger Clin* 1976;40:505–507.
23. Bates M: Themes in group counseling with adolescents, in Berkovitz I (ed): *When Schools Care*. New York, Brunner/Mazel, 1975, pp 56–68.
24. Pluzek Z: Efficacy of a treatment program for attempted suicides among youth, in Aalberg V (ed): *Proceedings of the 9th International Congress for Suicide Prevention*, Helsinki, Finland, 1977. Helsinki, Finnish Association for Mental Health, 1978, pp 114–118.