Report of the
Commissioner's Task Force
on Self-Destructive Behaviors
and Teen Suicide

December
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Susan B. Parker, Commissioner

Department of Mental Health and Mental Retardation

ASSOCIATES

STANLEY J. EVANS, M.D., P.A.

PRACTICE LIMITED TO ALCOHOLISM AND OTHER CHEMICAL DEPENDENCIES

January 8, 1988

Susan B. Parker, Commissioner
Department of Mental Health & Mental Retardation
State House Station #40
Augusta, ME   04333

Dear Commissioner Parker:

On behalf of the members of the Commissioner's Task Force on Self Destructive Behaviors and Teen Suicide, I am pleased to present our findings and recommendations. This REPORT provides an insightful and creative synthesis of the best current knowledge on the factors that contribute to self-destructive behaviors, and it provides a comprehensive approach for understanding, preventing, and treating teen self-destructive behaviors.

The diversity, knowledge and dedication of the members of our Task Force was a major asset in developing the comprehensive approach proposed in this REPORT. The group included concerned citizens and professionals, adults and teenagers. Police, clergy, parents, nurses, social workers, volunteers, students, and educators were represented. It has been a privilege to work with this group of caring and committed citizens, all of whom gave of their time and energy to the development of this REPORT. I also want to express my appreciation to Task Force staff, including Dr. Rachel Olney of the Child and Adolescent Service System Project, who synthesized a mountain of research and information and the diverse views of the Task Force members.

We commend you for your concern for the quality of life of the teenagers of Maine and their families, and for seeking a collaborative and comprehensive approach to this incredibly complex and difficult issue. I know I speak on behalf of the entire Task Force in offering our personal assistance in implementing the Recommendations of this REPORT.

Sincerely,

Stanley Evans, M.D.
Chairperson

For

Thomas Landers

In Memoriam

Whose Humor, Compassion,

and Commitment to

Maine Teenagers

Inspires this work

TABLE OF CONTENTS

FORWARD

This Report is designed to provide a unified policy direction for understanding, preventing, and treating teen self-destructive behaviors and suicide. It began with the presentation of a preliminary report on this subject to the Commissioner of the Department of Mental Health and Mental Retardation in March, 1986. That report, authored by the Child and Adolescent Service System Project, outlined the dimensions of these problems in Maine, and recommended establishment of a broad-based Task Force to consider coordinated, community-based approaches to addressing them.

The Task Force included citizens from throughout Maine. The group included concerned citizens and professionals, adults and teenagers. Police, clergy, parents, nurses, social workers, volunteers, students, educators and others were represented. In five meetings, the Task Force heard speakers and held discussions on family, school, community, and peer approaches to prevention and intervention.

Dr. Stanford Friedman began by defining self-destructive behaviors for the group, and addressing the developmental background of these behaviors, as well as outlining areas of possible solutions. Dr. Lee Salk presented his research on pre- and perinatal risk factors for suicide; and addressed the roles for families in preventing self-destructive behaviors throughout development. Dr. Perry London challenged the Task Force's views of education, calling for "character education" in schools as a means not only for preventing self-destructive behaviors, but also for raising children who are better prepared to become responsible, competent adutls. At an especially informative and powerful meeting, teen peer helpers (and their adult guidance counselors and trainers) from throughout Maine met with the Task Force, to discuss teenagers' views on adolescence and self-destructive behaviors, and to present their experiences helping troubled peers. The final experts were the Task Force members themselves, each representing different approaches that communities, professional groups, and concerned citizens take to addressing self-destructive behaviors.

The Findings and Recommendations of the Task Force on Self-Destructive Behaviors and Teen Suicide have been synthesized from these discussions. They represent a set of priorities and policy directions for State and local government, and for agencies and communities. They are guidelines, directed toward long-term changes in families, schools, and communities. Lasting solutions will be found in the strength of Maine's communities -- among each teenager's family, friends, and neighbors.

i

MEMBERSHIP

Task Force on Self-Destructive Behaviors and Teen Suicide

Department of Mental Health and Mental Retardation

Rep. Carol Allen
RFD#1, Box 1980
Liberty, ME 04940

Margaret Burton, R.N.
Jackson Brook Institute
175 Running Hill Road
So. Portland, ME 04106
Tel: 761-2200

A.L. Carlisle
Associate Commissioner
Department of Corrections
State House Station #111
Augusta, ME 04333
Tel: 289-2711

Benjamin Chandler, Jr.
P.O. Box 824
Portland, ME 04104
Tel: 797-9087

Debbie Clark
Crisis and Counseling Center
79 Sewell Street
Augusta, ME 04330
Tel: 623-4511

Stacy Cummings
Route #3
Gardiner, ME 04345

Jonathan Edwards, Ph.d
Dean of Students
University of Maine
Machias, ME 04630
Tel: 255-3313

Stanley Evans, M.D., Chair
P.O. Box 4095, Station #A
Portland, ME 04101
Tel: 774-1566

Mike Fasulo
Department of Human Services
5 Mechanic Street
Houlton, ME 04730
Tel: 532-9531

Karen Hartnagle
Div. of Probation & Parole
Dept. of Corrections
26 Franklin Street
Bangor, ME 04401
Tel: 947-8331

Thomas Landers
Chief
Bath Police Department
(Deceased)

Donald Lynch
Unity College
Quaker Hill Road
Unity, ME 04988
Tel: 948-3131

Charles Meredith, M.D.
Superintendent
Bangor Mental Health Institute
656 State Street
Bangor, ME 04401
Tel: 947-6981

Neil Michaud
Diocesan Human Relations Svcs.
519 Ocean Avenue
Portland, ME 04101
Tel: 871-7428

Charlene Milliken
P.O. Box 371
Hampden, ME 04444
Tel: 862-3059

Selena Pease
122 Brunswick Avenue
Gardiner, ME 04345

Peter Sentner
Client Service Director
York County Counseling Services
P.O Box 617
Saco, ME 04072
Tel: 282-7504

Canon Roger S. Smith
RR#5
Augusta, ME 04330
Tel: 622-2188

Nick Weingarten
Family Therapist
1776 Broadway
So. Portland, ME 04106
Tel: 774-3564

Helen Zidowecki
Acting Deputy Director
Bureau of Health
Department of Human Services
State House Station #11
Augusta, ME 04333
Tel: 289-3201

STAFF

Department of Mental Health and Mental Retardation
State House Station #40
Augusta, ME 04333

Robert Foster
Director
Bureau of Children with Special Needs
Tel: 289-4250

Jamie Morrill
Coordinator
Substance Abuse Services
(presently Associate Deputy
  Commissioner
Department of Human Services)

Rachel Olney
Director
Child & Adolescent Service
  System Project
Tel: 289-4251

James Harrod
Technical Assistance Coordinator
Child & Adolescent Service
  System Project
Tel: 289-4251

Kevin Redmond
Planning and Research Assistant
Tel: 289-4206

INTRODUCTION

"We often wish that we could somehow affect changes in the living patterns of our loved ones and our friends, especially those behaviors which seem obviously to nibble at the length and the quality of their lives. These behaviors include excessive smoking, drug ingestion, taking risks, disregard of the canons of ordinate prudence and common sense, and those other 'stupidities' of life that seem to unnecessarily demean or truncate life, or even to put life at risk."

Shneidman, 1985

For many teenagers, adolescence is a period of extremes - in styles, in moods, and in behaviors. Typically, these highs and lows, loves and hates serve important developmental functions, helping each teenager clarify his or her own unique identity, and preparing for the work, intimacy, and community and family life of adulthood.

But development may take other courses. For some, these extremes become dangerous ends in themselves. When serious emotional problems trouble an adolescent, self-destructive behaviors may be the unfortunate, and often tragic, result. Feeling angry, rejected, frustrated, helpless and directionless, some teenagers bring meager coping skills to a hard and inhospitable adult world. Seeking meaning, or escape, or comfort, they may turn to alcohol, or drugs, or sex, or violence, or self-abuse. They become dangerous to themselves, and often dangerous to their communities.

Teen substance abuse, homelessness, pregnancy, delinquency, depression and suicide have traditionally been viewed as distinct problems, calling for distinct solutions under the purview of separate agencies or groups. While considerable expertise has been lent to such efforts, these compartmentalized approaches have had limited effects. The common roots of these diverse self-destructive behaviors call for common solutions as well.

Most teenagers adapt well to the rapid changes of adolescence. Like adults, they have their ups and downs -- but most are not in turmoil. The majority of teenagers enjoy life most of the time; have good relationships with their families and friends; and are hopeful about the future.

But even for this majority, adolescence may bring serious conflicts. Although most teenagers weather these conflicts well, others may be nearly overwhelmed by them. Discord occurs at home over rules, chores, moodiness, and other issues as teenagers struggle for autonomy. Boredom, restlessness and alienation result at school from the passive pursuit of an education whose goals are defined and structured by adults. Without meaningful goals to pursue, or productive uses for their knowledge and skills, even the most "normal" teenagers at times become angry or depressed.

For a significant minority of teenagers, such negative feelings and experiences become overwhelming. As many as 12% of all teenagers may be emotionally disturbed (Gould, Wunsch-Hitzig, and Dohrenwend, 1981). Unfortunately, these disturbed teens may become self-destructive. Self-destruction may be slow, as in truancy or chemical dependency; or quick, as in overdosing or self-mutilation. It may be hidden, as in depression or bulimia; or it may be flagrant, as in promiscuity or OUI. This appears to be an overwhelmingly diverse group of problems. But although the means, manner, and speed of self-destruction may differ, these teenagers share common mental health problems.

CHARACTERISTICS OF SELF-DESTRUCTIVE TEENS

Chemical dependency. Chemical dependency is a widespread problem among teenagers, as it is among adults. In Maine in 1985, 10% of adolescents aged 13 to 18 were alcoholic; 12% of high school seniors drank daily (Maine Department of Educational and Cultural Services, 1985). According to national data, 60% of 6th graders felt "pressure" from peers to take drugs (National Institute of Drug and Alcohol Abuse, 1986).

Alcohol continues to be the drug most frequently abused by teenagers in America today. However, more and more teenagers are apparently turning to poly-chemical abuse, which involves the abuse of more than one drug. According to a recent survey by Maine's Department of Educational and Cultural Services, one-third of Maine's teenagers said that one in five of their friends had used hard drugs. Similarly, 82% said at least one of their friends used marijuana regularly. Overall, it is estimated that of the roughly 86,000 Maine teenagers, 5,500 have used, or are using hard drugs, and that 25,000 have used, or are using marijuana.

Teenagers who abuse alcohol and other drugs tend to engage in other dangerous behaviors as well. In 1986, 2,215 Maine teenagers (13-19) were arrested for drug & alcohol violations (excluding O.U.I.). That same year there were 769 arrests of juveniles ages 13 to 19 for OUI, and 1,569 administrative suspensions of drivers' licenses for drivers age 20 or under operating with blood alcohol level of 0.02 or more. Another 159 licenses were suspended for teenagers refusing to take the blood test. In 1985, there were 24 fatalities in auto accidents involving a teen operating a motor vehicle with a blood alcohol level of 0.01 or more; 14 occurred in 1986. Half of adolescent deaths in automobiles are attributable to alcohol (Maine Department of Public Safety, 1985, Bob Farris).

Substance abusing teens engage in other risk-taking behavior as well: 60% of serious juvenile offenders at the Maine Youth Center consumed drugs or alcohol immediately prior to the offense (Maine Department of Corrections, 1985). Some take the ultimate risk: studies indicate that from 40% to 70% of all adolescents who commit suicide are drunk or high shortly before their deaths (Schukit, 1986).

Teenagers who abuse substances share the primary characteristics of other self-destructive youth. Many who turn to alcohol and other drugs lack significant sources of support from either peers or adults. Moreover, these teens may never have learned successful coping skills. This is particularly true among teenagers from addictive families. Lacking supports, unable to form meaningful, supportive relationships with peers or adults, these youth become increasingly isolated, which in turn increases the risk of further self-destructive alcohol or drug abuse.

Drugs aggravate the problems facing adolescents and often lead to depression, feelings of hopelessness and increased self-destructive behavior.

Co-dependence. Even if they do not become alcoholic or obviously chemically dependent, adolescents (and others) who grow up in family systems characterized by addictive processes are likely to develop their own disease:
co-dependence. The incidence of this disease is difficult at present to establish. Some researchers estimate that the majority of the population of the United States is so afflicted (see Schaef, 1986).

For self-destructive adolescents, the relationship between disease and behavior is clear. Co-dependents tend to withold, deny, or distort feelings. This, as well as their lack of boundaries between self and others, and their tendencies toward physical illness, gullibility, and dishonesty only begin to describe the ways in which co-dependent adolescents are seriously at risk of endangering themselves, and others around them.

Depression. One of the most prevalent problems among self-destructive teenagers is depression. Depression may be difficult to detect in adolescence, as it often manifests differently than in adulthood. Although depression is typically viewed as anger turned inward, for some teenagers this turns outward, manifesting as aggressive, destructive, antisocial behaviors. The seriously antisocial nature of these behaviors may draw attention away from the teenagers' serious underlying mental health problem. These teenagers are particularly easy to misunderstand and misinterpret.

Even when the symptoms of teenagers' clinical depression mirror those of adults, they may nevertheless be overlooked or misinterpreted, as these same symptoms occur in some degree in many normal adolescents. As teenagers, children may suddenly seem to be uncooperative, depressing, unpredictable strangers. However unpleasant, for most teenagers this is simply part of the process of separating from home and family. By contrast, the many sudden, dramatic changes and uncharacteristic behaviors of seriously depressed teens do not serve this healthy, long-range goal. Parents may see their honor student suddenly lose interest in school and fail several classes; their star athlete become lethargic, quitting his/her teams; their healthy teen suddenly lose (or gain) a lot of weight; their sensible child take unreasonable and dangerous risks with liquor, drugs, cars, promiscuous sex. These are typically not part of adolescent rebellion, and should cause parents and friends to suspect more serious, persistent depression.

"Quietly disturbed" adolescents. The serious emotional and mental health problems of some teenagers are not identified and recognized. If they emerge at all, they may take dramatic and desperate forms, such as suicide. According to conservative estimates, at least 12% of teenagers are emotionally disturbed, and of these, one-third are "quietly disturbed." These are teenagers who are not visibly disturbed or delinquent, and therefore have not come to the attention of mental health or law enforcement authorities on more than one occasion. Since these teenagers appear moderately well adjusted, teachers, parents and others are less likely to worry about them. At least the quietly disturbed teens are not angry and aggressive, like others who are obviously self-destructive.

-4-

Their better impulse control and family relationships may mask these teens' need for help. However, with self-images comparable to more disturbed teenagers, the quiet group may nevertheless be at serious risk for self-destructive behaviors (see Ostrov, Offer & Hartlage, 1984).

Conduct disorders. As many as 3.5% of all teenagers are conduct disordered, and may be at serious risk for self-destructive behaviors (Rutter, Tizard and Whitmore, 1970). Their violations of social norms and of the rights of others draws attention away from their underlying mental health problems, focusing instead on symptoms and behaviors: rudeness, rule violations, truancy, substance abuse, promiscuity, criminality, etc.

For conduct disordered teens, antisocial behaviors fit into an overall picture of cognitive and social deficits. Both currently and historically, these teenagers typically have problems at school. They may achieve below grade level, also showing little interest or enthusiasm for school. Compounding this may be a history of hyperactivity during childhood. These impulsive, restless, inattentive children are overrepresented among conduct disordered teenagers. Deficiencies in problem-solving skills and social skills, as well as rejection by peers further complicate the problems these children and youth have making appropriate social and scholastic adjustments (see Kazdin, 1987).

Despite their dislikable characteristics, these youth share with their quieter peers a dangerously self-destructive bent. They jeopardize their own health and safety in addition to (or in process of) annoying or endangering others. This is most serious for youth who are depressed as well as conduct disordered, sharing with the former group feelings of hopelessness, powerlessness, and lack of control. For this group, drinking and driving and other forms of recklessness may represent suicidal or parasuicidal behavior, rather than simply the angry rebellion or self-centeredness of other youth performing the same unacceptable behaviors.

Suicide and attempted suicide. Suicide represents the ultimate form of self-destructive behavior. For Maine teenagers, suicide is the second leading cause of death. Over the past ten years in Maine, the suicide rate has averaged approximately 12 documented suicides per year, with 9 in 1986 (Maine Department of Human Services, Bureau of Vital Statistics, 1977 - 1986). Although successful suicide is a relatively rare event, compared to other forms of self-destructive behaviors, suicide attempts and gestures are rather more common. A survey of psychiatric emergency room admissions at Maine Medical Center found that, during a typical month in 1985, there were eight (8) admissions of children and adolesents 18 years of age or younger for suicidal threats, gestures or attempts, or for overdoses (Hawkins, 1986). Extrapolating from these data, there may be approximately 96 such admissions per year at Maine Medical Center alone, and approximately 480 statewide. This is consistent with national prevalency estimates that for every known, completed suicide there are at least 10 and possibly 100 attempts (Eisenberg, 1980).

Severe stress or crisis may exacerbate depression, and lead to suicidal tendencies in depression prone teenagers. For them, normal life crises such as parental discord or divorce, breaking up with a boy/girlfriend, school failure, or serious illness overtax their limited or fragile coping skills. Even in times of crisis, these frequently socially isolated youth find little support among peers and family. This support may be unavailable, or may be available but unrecognized or unaccessed by the teenager. Without experiencing such support, feelings of self-blame, guilt, anger and futility produce serious results.

FACTORS CONTRIBUTING TO SELF-DESTRUCTIVE BEHAVIORS

It would be reassuring to point to a single factor, or set of factors, responsible for teen self-destructive behaviors. It would also be wrong. Self-destructive behaviors, like other human behaviors, result from the complex interaction of many processes and events.

Developmental Factors. The challenges of adolescent development -- coping with complex physical, emotional, cognitive and social changes - increase the vulnerability of some teenagers to self-destructive behaviors. For adolescents and their families, this is often a difficult time. Physical changes bring about not only a complete change of body image, but unpredictable and uncontrollable events (pimples, voice breaks, etc.) and moods which increase stress and test teenagers' coping skills. In addition, sexual maturity requires not only adjustment to the new (and largely unchangeable) shape of the personal physical reality, but to the mastery of unfamiliar impulses which are difficult to discuss with others, and for which appropriate behavioral models may be scarce, or hidden.

Cognitive changes accompany these physical ones. With a qualitative increase in the ability to conceptualize abstractions, adolescents find themselves able to envision in detail personal, familial, and social realities quite different from present circumstances. The discrepancy between daily life and these idealizations is a source of discomfort for many, motivating development of new personal goals, or changed relationships with family members, or perhaps social activism. For others, the discrepancy between reality and fantasy becomes a source of almost unbearable disappointment, frustration, and pain.

Physical and cognitive changes are only two factors complicating the development of identity. For the adolescent, the answer to the questions "Who am I? What am I to become?" are no longer clear (see Erikson, 1968). Developing answers to these questions of personal identity, moral values, and vocational goals requires active search by the adolescent: these cannot be imposed from without. Most adolescents succeed in these tasks. For some, however, presented with a highly restricted or negative range of adult roles from which to choose, the development of a "negative identity," or the failure to develop identity at all, may result. Delinquency and suicide are two possible outcomes (see Erikson, 1968).

Some of these identity issues are developed through interaction with parents and other family members; many others depend on peers and on role models outside the family system. The need for increased autonomy and independence during adolescence may increase family conflict as teenagers and parents struggle with shifting roles and re-defined rules. Limit-testing and rule violation may be normal ways of clarifying this changing relationship. However, at the extremes where parents attempt to retain extremely authoritarian control, or entirely abdicate control, adolescent reactions may be equally extreme, in the form of highly overt, visible rebellion, or less obvious but equally serious constriction and withdrawal.

During adolescence, peers become important sources of social and emotional support. Adolescent peer groups or cliques provide clear, temporary identities while members experiment with possible adult identities. With peers, the teenager finds not only a relatively safe context for experimentation with new identities, but also refuge from authority conflicts with others who are experiencing the same physical, emotional, cogitive and social changes. Teenagers spend their most enjoyable time with peers, and rely on them for support. Research on normal adolescents, resilient youth, suicide attempters and other high-risk youth all confirm the importance of peers (see Werner & Smith, 1982; Garfinkel, Hoberman, Parsons, and Walker, 1986).

Although teenagers may respect their parents, teachers, relatives, and others, they rely more on peers than on adults when they need help. For most teenagers, families nevertheless retain considerable influence on important decisions and attitudes. Unfortunate consequences may ensue for teenagers who lack a healthy balance between the priorities and values of family, and those of peers. Consequences may range from the premature, poorly considered adoption of parental attitudes and goals, to development of negative identity and countercultural roles offering little preparation for productive adult adjustment.

Social factors. Adolescents develop within a society which provides very limited opportunities for productive, meaningful contributions at home, at school, or in the community. School focuses on preparation for adult roles which are distant, meaningless, or incomprehensible to many teenagers, leading to considerable alienation from this important part of their lives. Outside of school, the labor market furnishes these unskilled workers with few opportunities for meaningful work. Teenagers engaged in routine, monotonous, poorly compensated work may actually learn more negative than positive lessons about their future roles in the labor force. Uninvolved and unengaged at school, largely superfluous in the world of work, and failing in the search for immediately satisfying, meaningful roles, teenagers may become frustrated, alienated, and depressed.

Many bored teenagers (like adults) turn to television and other media to pass time (Csikszentmihaly and Larson, 1984). The negative consequences of active teenagers spending their time passively and unproductively are one source of concern. The values and content of the media messages are another. Particularly through television, teenagers are exposed to numerous models engaged in self-destructive behavior. These models often are not shown experiencing the negative consequences of their behavior: i.e. the drinkers are not shown truly drunk, those engaged in indiscriminate sex are not shown contracting sexually-transmitted diseases, etc. Quite the contrary, many self-destructive behaviors, including certain forms of violence, may be glamorized. Given that people learn through observation of models, particularly ones perceived as powerful, these messages may have important negative consequences for bored, vulnerable teenagers viewing them.

Media may also increase vulnerability to self-destructive behavior through explicit depiction of such behaviors by teenage role models. Research on media coverage of teenage suicide points to a contagion effect resulting from television movies, news reports, and other coverage of teen suicide. Other recent work suggests that such media coverage may not increase suicides, but rather influence the means teenagers use to commit their suicides (Berman, 1987). But whether media coverage actually increases the number of teen suicides, or "merely" influences the means of their execution, clearly the media influence adolescent behavior. Those most vulnerable to self-destructive behaviors due to other factors (biological, developmental, social) are unfortunately more vulnerable to these influences as well.

Biological vulnerabilities. Certain biologically-determined vulnerabilities further complicate these developmental processes for some children, increasing their risk for self-destructive behaviors. Ample evidence supports the tendency for depression, suicide, and chemical dependency to pass from generation to generation. Although environmental explanations are important and obvious, it appears that biological factors also operate in perpetuating these disorders.

For instance, both major and minor depressive disorders have been shown by twin studies to have a genetic, heritable basis, and suicide, especially when associated with depression, has a genetic component. Research also indicates a genetic liability for impulsive aggressive behavior, a significant trait in suicide attempters and completers. In addition, twin studies have shown that certain forms of substance abuse disorder are also hereditary.

Biological vulnerability may stem from the prenatal and perinatal periods as well. Due to advances in neonatology, many babies are being saved today who would have died only a generation ago. In comparing the neonatal records of 52 adolescents who committed suicide before age 20, with the records of control subjects, Salk (1985, 1986) found significant differences in certain pre- and perinatal conditions. The suicide group was more likely to have experienced respiratory distress for more than 1 hour at birth; their mothers were more likely to have no prenatal care before 20 weeks of pregnancy, and to have a chronic disease during the pregnancy. While these factors alone clearly do not cause adolescent suicide or other self-destructive behavior, they may increase vulnerability, particularly when they operate in the presence of multiple other stressors.

Temperament appears to be a biologically-determined characteristic of each individual, present at birth. Temperamental differences make some infants easy to soothe, others hard; some quick to adapt to changes, others slow; some more sociable than others; etc. The match, or mismatch, between the child's temperament and the parents' may predispose to a smooth, or rocky, developmental course for the child. For a temperamentally "easy" child, chances of adjustment to the familial environment are good. For the temperamentally "difficult" child, however, mismatch may have serious, long-term repurcussions for development, possibly leading to behavioral problems later on (Chess and Thomas, 1986).

Family and environmental stressors. Families differ in their ability to cope with stress and change. Vulnerable children flourish in many families; they become self-destructive in others. The complex interaction of physical, social, emotional and economic stressors operating in these family systems may account for these differences.

Stress frequently results from changes, disruptions, separations and losses that are increasingly common in contemporary American families. Mobility, for example, may produce vocational, financial, or other advantages, but also increases family isolation. Distance from extended family members cuts off significant sources of useful advice, practical assistance, and emotional support. Moreover, neighborhoods composed of highly mobile, transitory residents tend to lack a sense of community, decreasing the likelihood that neighbors will provide significant sources of family support. Families increasingly raise their children without the types of readily available practical assistance and support common to previous generations.

Changes in family structure are also sources of stress. Family structure may change, and roles shift, as new members are born, as children grow up and leave home, or as older members die. Marital separation and divorce have also become common developmental and social processes in American families. The pervasiveness of these stressors does not, however, diminish their severity. Changes are long and painful, from the discord leading to the divorce, through the divorce process itself, financial changes, custody battles, and post-divorce adjustments.

Single-parent families are more and more common. Between 1970 and 1980, the percentage of such families increased by nearly 50%, comprising nearly 14% of all Maine families (U.S. Census). The single-parent family resulting from divorce typically faces decreased financial resources, and enormous emotional adjustments as the newly single adult adjusts to changed personal status and identity, and to the challenges of raising children alone; and as the children cope with their losses, and their altered family relationships and circumstances. At remarriage, blended families face further adjustments. As adults work to clarify the roles of parents and step-parents, and as children again wrestle with loyalties, authority issues and shifting family relationships, the multiplicity of changes produces considerable stress.

Where vulnerable children are raised in highly discordant families, experiencing acrimonious divorces and difficult post-divorce adjustments, the risk of adolescent self-destructive behavior increases. Disruptions and losses of all kinds tend to characterize families with self-destructive members more than comparison groups. Particularly in studies of attempted and completed suicide, the self-destructive groups tend to show more early loss due to separation, divorce, and parental death (see Paykel, 1986 for review). Children with suicidal ideation are more likely to come from families characterized by disturbed relationships and persistent discord, with the children suffering persecution, hostility, and abuse (Kosky, Silburn, and Zubrick, 1986). Recent family discord and losses are also more common among self-destructive teens, for whom the number of personal, school, legal and family-based difficulties may be overwhelming (Garfinkel, Hoberman, Parsons, and Walker, 1986).

Work patterns also distinguish contemporary families from those of previous generations. Today, the majority of women work: in 1985, 53% of all Maine women were in the labor force. By 1982, 55% of children under 18 had mothers in the work force, as compared to 40% ten years ago (Maine Department of Labor, 1987). While financial stress may decrease in two-earner families, work schedules pose impediments for raising children. Child care is a constant concern for most two-earner families, well through the elementary school years. In addition, household responsibilities must be shared among members who may or may not be willing to shoulder burdens traditionally viewed as solely mother's role. In families which successfully adjust to these challenges, children and adolescents learn powerful lessons about cooperation and responsibility. For others, feelings of resentment, exploitation, or martyrdom among family members maintains high levels of stress, and may contribute to the maladjustment of offspring.

For many families, economic stresses are fundamental characteristics of daily life. Added stress falls on families in (or near) poverty, and on the unemployed and under-employed. In 1980, nearly 16% of all Maine children lived below the poverty line. This translates to a staggering 50,000 children. Another 7%, or an additional 23,000 children were "near-poor," living at 125% of the federally-defined poverty level (U. S. Census). These families struggle to meet basic needs while also facing the isolation, divorce, and household problems faced by other Maine families. A family's inability to provide for basic needs is itself a tremendous emotional stress, and may increase the effects of other stressors to intolerable levels. Addressing children's needs for physical and emotional security and predictability in these circumstances is difficult at best.

FINDINGS AND RECOMMENDATIONS

Preamble

A teenager never becomes self-destructive due to a single event or cause. No one factor -- developmental problems, mental health problems, social or family stresses, or biological vulnerability -- alone can account for such complex behaviors.

The Findings and Recommendations of the Task Force reflect this complexity. They present no simple solutions or quick fixes. It is the opinion of the Task Force that none such exist. Instead, the Findings and Recommendations reflect the group's distillation of appropriate avenues for long-term prevention efforts.

These issues strike to the heart of family and community life. The Task Force firmly believes in the strength of Maine's families, and the ability of teenagers, parents, neighbors, and friends (with help from state and local government) to make adolescence a safe and fun time for all.

FINDINGS AND RECOMMENDATIONS

I. <u>Families that foster normal development for their children provide the best prevention of self-destructive behaviors.</u>

As children progress through the stages of normal development, they build personal strengths and social supports. Families prepare their children to succeed socially, scholastically, and vocationally and arm them with skills and strategies for coping with life's all-too-predictable stresses, crises, and tragedies.

<u>Families that foster normal development for their children recognize and value each child's unique characteristics. They respect their children and demonstrate their respect regularly in action and in words.</u>

These families provide emotional support, encourage autonomy, and establish behavioral limits appropriate to the age and competence of each child. They listen to their children. They are sensitive to their children's individual needs and interests.

Balance is a theme for these families. Teenagers are treated neither as children nor as adults. The reasonable rules established for them balance their needs for autonomy and independence with appropriate measures of supervision and guidance. Expectations for sharing in family matters, including daily household tasks, balance the families' need for participation and the teenagers' many skills and increasing desire for separation from family demands.

Families demonstrate their respect for their children's decision-making and problem-solving abilities. Within a supportive environment, parents provide physical and emotional privacy for their teenagers, trusting them to solve their own problems where they are able and to seek help when in need.

Children develop an understanding of their strengths and weaknesses from their families. With a strong self-concept, gained from families' realistic appreciation of skills and accomplishments, children and adolescents cope effectively with knowledge of their shortcomings and failures.

Families that foster normal development teach appropriate means of self-expression.

Both overtly and covertly, intentionally and unintentionally, families teach children ways to express emotions. Children learn indirectly by observing their parents' behavior. They see their parents' reactions to failure, frustration, fear, and stress; their behavior during crises; the internalization or externalization of their angry feelings. They learn from these examples. Children also experience consequences, from their parents, for their own hostility or anger, learning from these the times, places, and manner in which they are permitted to show feelings.

In the course of normal development, children learn that the "negative" emotions (anger, guilt, fear, envy, etc.) are common to everyone. They learn, further, many different strategies for coping with them and for expressing them. Particularly during adolescence, appropriate expression of powerful emotional ups and downs within a supportive family decreases the likelihood of self-destructive expression of these same feelings.

II. Nurturing, supporting, guiding, and, finally, letting go of children involve complex, difficult tasks. Society, at present, offers parents no preparation, or on-going support, for these responsibilities

Parents try very hard to be "good" parents. However, for today's nuclear families, single-parent families, families with two working parents, and for the increasing number of families emotionally or physically distant from extended families, parenting proceeds in the absence of information and support which were readily available for previous generations. Simultaneously, the complexity of parenting has increased, as threats to the safety of children — through drugs, crime, disease, and other sources — continue to challenge families.

As a society, we expect parents to socialize healthy, productive citizens. This expectation carries with it a parallel responsibility: for society, in the form of communities, schools, churches, businesses, and neighbors, to assist and support families.

Parents cannot be expected to execute their many repsonsibilities alone. Many institutions (churches, schools, media) and individuals (relatives, neighbors) can provide important information about parenting and family life. Publically and privately, these institutions can demonstrate their recognition and appreciation of parents. More specific, concrete demonstrations of support are also needed. **The Task Force recommends continued development of "family supports," including respite care, parent support groups, and any other services that strengthen family life.**

III. Natural helping networks, informal support systems and volunteers are uniquely well equipped for prevention of and intervention in self-destructive behaviors.

Effective prevention of and intervention in self-destructive behaviors is best performed by those with informal, routine contacts with parents and teenagers. Friends, neighbors, babysitters, clergymen, physicians, lifeguards, and Scout leaders are a few examples of natural helpers with regular, natural opportunities to help and encourage families of high risk teens.

Natural helpers can provide support for teenagers unwilling or unable to gain this support from their parents

Clearly, parents are primarily responsible for guiding and encouraging their children. However, as teenagers strive for independence from parental authority, they may also distance themselves from their families' warmth and security. Isolation and possible self-destructive reactions may result for teenagers who believe that no adult cares for or about them. **The Task Force encourages parents to work with their children in establishing and maintaining relationships with adults outside the family, thereby decreasing these risks.**

Natural helpers can assist and advise parents through predictable,normative developmental crises and through periods of family upheaval and stress.

With parents, as well as with teenagers, natural helpers are uniquely well situated to offer support and assistance at times when families are especially willing to accept help. Assistance from these natural helpers does not constitute an admission of inadequacy or weakness nor does it diminish the central importance of parents in the lives of their children. Rather, it demonstrates their understanding of the complexity of their roles as parents and the extent to which the well-being of all family members benefits from external, as well as internal, support. **We encourage families and natural helpers to work together toward these goals.**

Trained volunteers can offer important support for parents and teenagers.

Members of many community organizations, churches, and civic groups are motivated and skilled at helping families. With training on specific issues, they provide very effective support to vulnerable children and their families. As with natural helpers, the timing and circumstances of the volunteers' assistance is less intrusive (and therefore may be more appropriate or more effective) than similar assistance from social service or mental health professionals. Volunteers may be useful in crisis situations, for the same reasons. **The Task Force encourages the use of volunteers in family support activities.**

-15-

Schools, health care providers, and religious institutions are well situated to prevent and intervene in self-destructive behaviors.

Because of their unique roles in advising, guiding, and teaching children and families, these non-mental health professionals constitute informal community supports for families.

Support for children and teenagers in schools traditionally comes from guidance counselors, special education staff, teachers, and other pupil support services staff. However, other school personnel (secretaries, cafeteria staff, etc.) are extremely effective when trained and recognized in this role. With their extensive contact with students, these personnel are particularly well positioned to prevent self-destructive behaviors or detect their early occurrence. **The Task Force encourages recognition and support for these natural helpers in schools.**

Particularly during important transitions (such as those between elementary school and junior high or junior high and high school), schools can provide important preventive information for parents. Similarly, preventive information can be routinely delivered by guidance staff, social work staff, teachers and others in routine contacts.

Through routine contacts with families, health care professionals exercise considerable influence on children and families. Information about normal adolescent development, delivered by physicians during routine family contacts, may be a powerful preventive tool. Effective prevention with parents emphasizes positive aspects of adolescence, rather than addressing only developmental crises and stresses. **We recommend increased training for physicians on these issues, both in medical school, and via continuing education and conference programs. We further recommend increased collaboration and consultation with mental health professionals.**

The emphasis at churches and synagogues on spiritual growth suits these institutions particularly well to deal with many teenagers' concerns. The family events, youth groups, community ministries, and volunteerism at many churches and synagogues provide a special type of support for families. **We support the religious community in its ongoing prevention and intervention with teenagers and their families.**

IV. Peers provide essential help and support for other teenagers.

Friends and age-mates support teenagers in ways adults cannot. Parents and other adults may meet some of teenagers' needs, such as security and nurturance; however, adults cannot meet many other needs. As adolescents establish their independence from their families and increasingly question the expertise and authority of their elders, advice and intervention in certain areas from adults may be less welcome than similar information from peers. Privacy from adults may be particularly well protected in areas most related to self-destructive behaviors. Teenagers are much more likely to discuss broken relationships, substance abuse, and a range of other problems with each other than with adults perceived as authorities over them.

Adults, such as parents and school officials, indirectly offer support by encouraging contacts with friends. This support is particularly necessary for vulnerable teens.

The development of peer supports is an integral part of normal adolescent development. The importance of friends and age-mates on some issues does not necessarily imply inadequacy of parental or other adult supports. Rather, adults and peers fulfill different roles in the lives of most adolescents.

Unfortunately, some teenagers at risk for self-destructive behaviors do turn to peers to address needs for security, guidance, or affection not met by adults. While re-orienting these most vulnerable teenagers to seek adult help constitutes a worthwhile long-term goal, peers may be effective more immediately in prevention of and intervention in self-destructive behaviors. **We encourage adults to facilitate the appropriate use of peer supports by teenagers.**

For most teenagers, friends provide peer support. For those teenagers without such naturally-occurring peer networks, more formal, structured forms of peer support may fill this need.

Small group activities in churches, schools, and other community settings may help teenagers share feelings and deal with stresses. Such groups help teens lose their sense of isolation and build self-esteem.

The Task Force recommends greater availability of different types of small group activities in a wide variety of settings. The most effective programs are tailored to suit the characteristics of individual schools and communities and maximize naturally-occurring opportunities for prevention, such as transitions between middle-school and high-school.

Peer helper programs in schools constitute a particularly effective form of structured support and intervention.

These school-based programs provide students opportunities to talk with trained peer "helpers" or "counselors." The peer helpers work under the supervision of a guidance counselor or social worker, who monitors their activities and receives referrals from them of students whose serious problems (pregnancy, substance abuse, suicidality, etc.) go beyond the peer helpers' skills and repsonsibilities. These programs are located at high schools, middle- or junior-highs, or may involve older students with younger, elementary-level students.

The Task Force recommends concrete demonstrations of support from parents, community members, school officials, and fellow students for these programs and for those who participate in them. Encouragement from families and community organizations is important for the establishment and continuation of these programs. In order to succeed, these programs require financial support (e.g. for student and staff training). Flexibility and understanding within the school are also necessary in order to provide peer helpers, assist students seeking help with release time from classes, find space and privacy for meetings, and incentives for participation, such as academic credit.

V. Schools have considerable influence on children, in educating them and in shaping character and self-concept. Schools may play critical roles in preventing self-destructive behavior among teenagers.

Schools provide education and guidance for children many hours each day for many years. Clearly their most important role is teaching academic skills. However, their influence extends considerably beyond this role. Schools mold the behaviors, skills and attitudes the community expects of its citizens. In addition, through regular feedback to children regarding strengths and weaknesses, schools shape self-concept and self-esteem.

Given their universal access to children and young adolescents, schools face a difficult dilemma. They are increasingly asked to carry out functions formerly carried out at home and in the community: health care and mental health services are two examples. For many children, school provides the only avenue for access to these services. It remains an open question whether schools are able to fill all these gaps to the satisfaction of all concerned or, in fact, whether it is appropriate for them to do so.

Parent involvement in schools is critical.

Students, families, and schools all benefit from increased parent involvement. Implementation of this goal requires assistance and training for both parents and school personnel, as well as increased flexibility within the educational system. Teachers may benefit from specific training on ways to communicate with parents. Parents, similarly, may benefit from support and training regarding ways to deal with school authorities. Given practical obstacles to parent involvement, such as conflicts between work schedules and normal school hours, creativity and flexibility by school will also be necessary. **The Task Force recommends schools increase their efforts to involve parents in their children's education through parent volunteerism in the schools; through engagement of parents during regular parent/teacher conferences and outreach to parents on other occasions; through parent involvement in curriculum design; and by any other creative means such as adjustment in hours of teacher conferences and other meetings to accomodate working parents.**

When schools individualize curricula and teaching strategies, they increase chances for academic success and thereby increase self-esteem.

Success at school is narrowly defined, at present, by good grades in academic subjects. Some students enjoy this competition and excel at it. For others, however, school is at best boring, uninteresting, or irrelevant to their lives and goals. At worst, some of these students find school a constant reminder of personal inadequacy and failure. **We encourage schools to address the effects of competition on these students.**

By introducing more flexibility into curricula and teaching methods, some of these problems can be addressed. Curricula and teaching methods can be adjusted to suit the unique characteristics of each student, identifying and building on each student's strengths. Certainly, success is more likely within such individualized programs, thereby increasing self-esteem for many who presently fail.

Many teachers share this goal, but are unable to implement strategies to attain it. The demands of large classes and full teaching schedules preclude such flexibility. For those school personnel already committed to individualized programming, encouragement as well as concrete support from school officials is necessary. **The Task Force recommends increased flexibility in school curricula and support for teachers and school personnel in achieving this.**

Opportunities for character-building are present throughout the curricula and, in fact, throughout the entire school experience.

Through experiences in and out of the classroom, schools teach many of the values and behaviors expected of adults in their roles as workers, family members, and citizens. By preparing students to be productive, responsible adults, schools also prevent self-destructive behaviors.

Some aspects of this instruction are explicit in course topics ranging from Civics to Psychology. Other teaching opportunities are manifold, occurring everywhere from the athletic field to literature interpretation. When students debate the ethics of genetic engineering in science class or confront issues of self-concept, cooperation and competition on the playing field, school fills an important function well beyond course content. **We support schools in their efforts to teach responsibility, cooperation, decision-making, and similar skills which will be necessary for adult adjustment and will also prevent self-destructive behaviors.**

Students' experience of school extend well beyond time spent in classes. School governance and discipline, extracurricular activities, and peer support also afford opportunities for teenagers to demonstrate the qualities we expect of them upon graduation. Surely students who shortly will vote, pay taxes, sign contracts, and raise families might have input into school decisions at least in such areas as smoking policies or extracurricular activities budgets.

The comprehensive health curriculum offers excellent opportunities for prevention of self-destructive behaviors.

The Task Force encourages the use of the recently mandated comprehensive health curriculum for prevention of self-destructive behaviors. Within the health curriculum, students might learn comunication skills, stress reduction strategies, and decision-making. General developmental issues can be addressed in this forum, including the normality of authority conflicts, mood swings, self-doubt, and other stressors during adolescence. The dangers of specific self-destructive behaviors, such as substance abuse and teen pregnancy, are also very appropriate topics.

Incentives, support, and training for school personnel will increase schools' capacity to individualize instruction, foster creativity and self-esteem, and implement other prevention strategies.

Many school personnel share these goals. **We encourage assistance and support for teachers interested in working toward these goals.** This assistance begins with revision of school priorities and policies to emphasize character education and curricular flexibility. Other recommended changes include incentives for teacher initiatives in individualized instruction and recognition for those who encourage students' creativity and self-esteem.

The Task Force recommends training for teachers and other school personnel in implementation of these prevention strategies. Beginning in undergraduate teacher education programs and continuing through in-service programs, recertification courses, conferences and workshops, training should emphasize developmental stages and issues, methods for fostering self-esteem, character education, and related prevention strategies.

Training builds teachers' confidence and skills. However, teachers need other forms of support if they are to model confidence, responsibility, self-esteem, and other positive adult characteristics for their students. Supports for teachers have been discussed in a variety of public forums. **We encourage continued efforts to address salary issues; greater professional recognition; increased community support for and involvement in education; and related issues.**

VI. Many of the teenagers most at risk of self-destructive behaviors are disaffected from adults, from mainstream values, and from activities perceived to typify these values. Developing innovative ways to reach these teenagers represents a major challenge.

Many forms of prevention and intervention presuppose teenagers' basic commitment to mainstream values and activities at home, at school, and in community life. Assuming such connections guarantees failure. These high-risk teenagers have rejected these commitments, often with good reason: for many family means rejection and abuse, schools bring failure and boredom, and work represents a dull, daily grind for poverty wages.

Simple solutions do not apply here. School success may raise self-esteem for many adolescents but not for those who are already truants, dropouts, or runaways. Physicians cannot disseminate information to teenagers and families who receive no check-ups and attend no clinics. These youth, who are sometimes delinquents, sometimes abused, sometimes homeless, are more likely to know store clerks, pawnbrokers, police, and drug dealers than Special Education teachers, mental health counselors, or clergy.

Whether we seek to inform or reform, such efforts can only be made successfully on the teenagers' terms, on their turf. Their self-destructive behaviors in some way make sense for them; their life-style brings pleasure as well as pain or risk. Innovative work, undertaken in isolated rural areas, at roller rinks and arcades, and on the streets, will begin from this premise. For some members of the traditional service system, deeply held mainstream values may preclude participation in such unusual interventions. On the other hand, natural helpers, who are in daily contact with teenagers, may be quite effective in reaching them. The Task Force recommends consideration and implementation of creative approaches to addressing the needs of this population.

VII. Coordination among police, schools, mental health providers, other service agencies, and families significantly improves communities' effectiveness at prevention of and intervention in teenage self-destructive behaviors.

Prevention and intervention are clearly cooperative efforts. Although at any particular point in time, a single agency, service provider, or family member may lead such efforts, the complex problem of self-destructive behaviors cannot be adequately addressed by any individual or agency in isolation.

Clear communication is basic to effective coordination.

Successful prevention and intervention depend on clear communication between professionals and families, and among the professionals serving the family. Whether accomplished through formal interagency agreements and agency policies or through more informal linkages, routine sharing of information and resources enhances the community's ability to address self-destructive behaviors.

We encourage clear, regular information-sharing which serves the needs of teenagers and their families. Confidentiality is of paramount importance in this regard. The teenager's and family's direction regarding sharing (or protecting) various types of information always guides this process. The exceptions are few and clear: e.g. sharing information with parents against a teenager's wishes when s/he acts self-destructively or expresses such ideation.

Given the focal role of schools in the lives of children and adolescents, coordination between schools and mental health professionals is particularly important.

Given their nearly universal access to children, schools are frequently the focus of prevention and intervention efforts. Schools are already taking the lead in furnishing preventive information to children and adolescents. Input from mental health professionals, in the design and delivery of this information, can only improve their effectiveness. **We encourage a close relationship between school personnel and mental health professionals, particularly when teenagers are at risk for (or already engaged in) self-destructive behaviors.**

VIII.   Prevention is a community responsibility.

Preventing self-destructive behaviors serves long-run and short-run community interests. Clearly, the future of each community rests with its youth. Fostering their mental and physical well-being, and thereby helping them to become productive citizens, serves long-range community goals. More immediately, preventing teen self-destructive behaviors addresses the community's safety needs, as these youth frequently endanger not only themselves but others.

Active participation by teenagers in all aspects of community life benefits everyone.

In their communities, as in their families, churches, and schools, teenagers have important contributions to make. Involvement in activities which genuinely contribute to community life helps address some of the problems of aimlessness and superfluity which contribute to adolescent self-destructive behaviors.

No single solution will meet the needs of all teens and all communities. For some, service on School Boards, in public organizations, or as volunteers may be beneficial and appropriate. For other teens, more private contributions may be more attractive. But whatever the activity, everyone benefits from channeling adolescent energy into important tasks suitable to teens' maturity. **We encourage development of opportunities for adolescents to make meaningful contributions to their communities.**

Prevention plans are best devised and executed within individual communities.

We encourage localities to establish a community council to plan local prevention efforts. This group, including key community members, parents, teenagers, natural helpers, and local service providers can examine needs and plan prevention and intervention activities appropriate to them. Members of the Task Force are committed to assisting local councils in developing and executing these plans and further recommend that the State's youth-serving Departments collaborate in these efforts.

IX. Effective prevention begins with early identification and early intervention for children at high risk for self-destructive behaviors.

Research continues to identify biological and psychological risk factors which may predispose children to emotional disturbances or self-destructive behaviors. Children of parents who are depressed, suicidal, or alcoholic appear to be among those at increased risk of replicating these dysfunctional patterns. Effective, efficient prevention and intervention efforts target such high risk groups.

Where strong evidence points to high risk, prevention best begins at the earliest possible point in a child's development.

Early intervention during the neonatal period is more likely to have long-term positive effects in preventing self-destructive behaviors than are interventions undertaken later in development.

However, **given available information on family patterns for certain risk factors, we recommend even earlier intervention among certain groups.** This may include adult children of alcoholics, and those with family histories of depression, suicide, family violence, or other destructive behaviors. Consideration of these patterns, and their attendant risks, is appropriate when first planning a family. The assistance of natural and professional helpers — ministers, physicians, counselors, and others — may identify and attempt to resolve these risk factors before they affect any children.

While targeting high risk groups, judicious prevention and intervention efforts also respect family privacy.

Unless carefully pursued, early identification and intervention for children at high risk of self-destructive behaviors may increase rather than reduce risks. Violations of family privacy and creation of self-fulfilling prophecies are possible when identifying risks which are not yet behaviorally manifest. Research presently supports a relationship between certain risk factors and self-destructive behaviors. **Until and unless causal links are demonstrated, we recommend early identification and intervention efforts be pursued with caution.**

X. By changing certain policies, procedures, and priorities, public institutions and agencies will increase their effectiveness in prevention and intervention of adolescent self-destructive behaviors.

Responsibilities for prevention and intervention clearly extend beyond families, schools, churches, and natural helpers in local communities. The power of state and local government, and of large, influential public institutions (such as the media) can persuade and assist teenagers in numerous ways.

Restraint from broadcasting or printing information which models or idealizes self-destructive behaviors is a basic media responsibility. Media responsibilities also include dissemination of preventive information wherever appropriate.

Sensationalized accounts in print and broadcast media of teen suicides, accidents, and other self-destructive behaviors may have a serious negative impact on teenagers and on their communities. Imitative behaviors ensue for some teens, seeking the rewards (or simply the escape) portrayed for real or fictional models. These risks can be reduced, while the media continue to inform and entertain. **The Task Force recommends self-imposed monitoring by media on the type and character of models presented for teenagers, particularly in areas related to suicidality, substance abuse, and other self-destructive behaviors.**

Similarly, disseminating preventive information need not interfere with the art, entertainment, information, or other media goals. Although public service announcements and other means specifically targeted to prevention of self-destructive behaviors may reach some teenagers, the most effective messages are those woven into the fabric of television dramas and comedies. Consistent, realistic protrayals of the natural consequences of certain behaviors—that drinking makes people drunk, that unprotected sexual activity makes women pregnant—provide the most powerful messages.

Those adolescents formerly labeled "status offenders" are at considerable risk for self-destructive behaviors. System-wide improvements may be necessary to address their needs, as well as those of adjudicated juvenile offenders.

Elimination of status offenses moved runaways, truants, and others out of the juvenile justice system, but did not substitute other more appropriate services to meet their needs. In some states, statutes identify a group of "children in need of supervision," and provide access to services accordingly. **We support the study order of the 113th Maine legislature regarding Children in Need of Supervision and Treatment.**

Until and unless they are adjudicated of a delinquent offense (burglary, assault, etc.) many teenagers presently have little or no access to the comprehensive mental health, educational, vocational and other services they need. Even upon adjudication, limited resources restrict the juvenile justice system's ability to provide needed services and prevent escalation of criminal behaviors.

Early identification and intervention apply to adolescent offenders as well as to infants. Many of these children and adolescents are already engaged in self-destructive behaviors; others are certainly at considerable risk. Expeditious, comprehensive, coordinated interventions may prevent further, more serious escalation.

Substance abuse is the key to many self-destructive behaviors of adolescence. Combatting this requires a coordinated campaign of effective public policies, interventions, and preventive information.

Substance abuse is the most common form of self-destructive behaviors, for teenagers as well as for adults. It is also one of the most common contributors to other forms of self-destructive behavior. Addressing substance abuse and co-dependency is therefore critical to any comprehensive campaign to combat self-destructive behaviors of all sorts.

Preventing substance abuse is clearly more efficient and more effective than intervening once this becomes a problem. Successful prevention occurs throughout development, with parents, schools, community organizations and media providing consistent, age-appropriate messages. These messages include not only basic information regarding the dangers of substance abuse, but mroe importantly provide consistent support and assistance for children and adolescents in decision-making in many different areas. Children who make clear, firm decisions about their own lives and goals, who value themselves and the support of those around them, are less likely to engage in substance abuse, or any other type of self-destructive behaviors.

Comprehensive substance abuse prevention campaigns can proceed only where public policies and resources, at the state and local levels, support such efforts. In many Maine communities, such efforts have already begun through the leadership of schools and churches, with the assistance of local substance abuse counselors, mental health professionals, and concerned citizens. **The Task Force supports the continuation of these innovative approaches and encourages efforts to replicate their successes.**

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