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SUICIDE IN CHILDHOOD

A THESIS

Presented to the Faculty of

The College of Medicine in the University of Nebraska

In Partial Fulfillment of Requirements

For the Degree of Doctor of Medicine

Under the Supervision of Edward Beitenman M. D.

by

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Omaha, Nebraska

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CHAPTER I

INTRODUCTION

The problem of childhood suicides has been recognized for centuries, references being made in the lore of almost every culture. Juvenile suicide has been observed in tribes of Melanesia, New Zealand, British Columbian Indians, Sea Dyaks and others. References to childhood suicide appear in English Literature from Shakespeare (Romeo and Juliet) to Hardy(Jude the Obscure) and Beerbohm(Zuleika Dobson).[11]

Although many reports in the literature deal with suicide, relatively few are devoted to suicide in childhood. Several decades ago childhood suicide was considered quite rare if indeed possible. Only in recent years has an attempt been made to uncover suicide and suicide attempts which previously were disguised as accidents by parents, relatives and physicians. Today, many of these attempts are being recognized for what they are, an expression of serious underlying psychic, social and developmental problems. Evidence accummulating in places such as poison control centers is revealing the staggering proportions that this problem has reached. One authority estimates that suicide is the fourth leading cause of deaths in adolescents today.[17]Although vast sums of money and projects are devoted to organic disease, very little is being spent on a quite preventable cause of death, suicides in childhood. The training of physicians in the past has been primarily organic disease oriented with little emphasis given to psychiatric illness.

Today, however, the old taboos of childhood suicide have been swept aside and the subject is being discussed freely and the magnitude and seriousness of it appreciated. Although meaningful statistics on childhood suicide are scarce, more research is appearing each year in the literature dealing with this much neglected problem. As our knowledge of disease processes increases many of the major killers of children have been eliminated and others have been brought into focus, namely, suicide in childhood. Hopefully, with the increasing awareness and interest in this major problem, the energies of clinicians and researchers will produce an answer to curb the mounting statistics of suicide and suicide attempts in children. This paper will attempt to review the recent literature on childhood suicide and explore the findings and opinions of the various researchers.

CHAPTER II

INCIDENCE

Statistics on childhood suicide and suicide attempts are scarce and those which are available probably greatly underestimate the true incidence. Jacobziner, pointing out the problem of distinguishing between accidental death and suicides, feels that approximately 10 per cent of motor vehicle accidents and 15 per cent of home accidents have a suicidal component.[9] However, under current regulations in reporting vital statistics, unless there is a suicide note or other unquestionable evidence of suicide, the death is not classified as suicide. This problem in reporting is especially prevalent in those statistics dealing with the suicide of children since parents and relatives frequently "cover up" the suicide, making it appear as an accident. Shaw and Schelkun point out that methods used by children can easily be classified as accidents. These include jumping from heights, running into traffic or lethal ingestion of poisons.[20]

In the remainder of this chapter, all statistics will apply to children and adolescents unless otherwise stated.

Recognizing the variability of statistical reporting, some general conclusions regarding incidence may be drawn. In his review of the literature, Bigras found that:

> the proportion of suicidal attempts is twice as frequent in girls as in boys; that the number of suicidal attempts increases with age; that suicide is much more often successful with boys than with girls that there does not seem to be any special correlation betwween the suicidal act and the socio-economic level.[4]

Shaw and Schelkun feel that there is a variance is seasonal incidence with increases in the spring.[20] They cite Cavan's study of suicide in Chicago which showes that suicide rates increase with shifting populations and decrease with stable populations.[5]

Tuckman and Connon in relating suicide attempts to the hour of the day found that most attempts occurred from 3:00 P. M. until midnight in contrast to adults who prefer the early morning hours.[23] They also point out that there is an apparent racial difference with non-whites showing a greater incidence in proportion to their population. However, it is thought that this may be due to lack of reporting by private agencies which are utilized mainly by whites in contrast to non-whites who utilize public clinics more often. In contrast, Toolan found that Negroes commit suicide less frequently than whites when the statistics are adjusted for relative populations.[22] His study of Bellevue Hospital statistics for 1960 shows that a high percentage of attempts are made by Catholics(62 per cent) a religion which specifically prohibits suicide. This high incidence may be better interpreted by showing that most of these Roman Catholics were of Puerto Rican extraction, a population which shows a very high incidence of suicide in proportion to its relative population. He encountered fewer mental defectives in those attemtping suicides than in the general Bellevue Hospital population.

Position in sibling order was investigated by Lawler who found that the highest rates were found in the youngest and in the oldest child.[10] Toolan's study agrees with this finding.[22]

Table I represents the most recent available statistics on childhood suicide in the United States. It can be seen from the table that no figures are given for ages under five years of age. Rules for statistical reporting state that deaths of children under eight years of age are not tabulated as due to suicide regardless of the information entered on the death certificate. This rule obviously hampers accurate estimates of increasing or decreasing rates of suicide in the younger age groups. One interesting observation from Table I is the fact that the number of suicides in the age group 15-19 years is seven times greater than the number in the age group 10-14 years. This substantiates the belief that the suicide rate is much greater in the older adolescent group.

Since most authors agree that many suicides in children are disguised as accidents, it is interesting to note Table II dealing with deaths from accidents in 1966. If one is to accept the figure of one authority that 10 to 15 per cent of motor vehicle deaths and home accidents have a suicidal component, then it is obvious from Table II that the statistics listed in Table I do not nearly reflect the total deaths from suicide.[7]

A somewhat different approach is to examine incidence rates of suicide.[26] In 1964 the rate per 100,000 population in the age group 5-14 was 0.2. There was no rate increase from 1950 to 1964. In the 15-24 year age group the rate was 4.5 in 1950 and 6.0 in 1960, substantiating the claim that suicides are increasing in the adolescent population.

The reporting for the 5-14 year age group may be somewhat misleading since, as was previously noted, no suicides below the age of eight years are recorded regardless of the physician's listing suicide as the cause of death. The increase in the 14-24 year age group is due primarily to the increase in male suicides. The rate in 1950 for male suicide in this age group being 6.5 and increasing to 9.2 in 1964. The corresponding female suicide rate in this age group remained relatively stable at 2.6 in 1950 and 2.8 in 1964. The white and non-white rates were essentially the same; however, these rates were not adjusted for relative population.[26]

TABLE I

DEATHS BY SUICIDE
1966

	Total	5-9years	10-14 years	15-19 years
Suicide	21,281	1	115	765
Suicide by poisoning	5,588	-	6	174
Hanging and strangulation	2,863	-	51	131
Firearm and explosive	10,407	1	53	396
All other means	2,423	-	5	64

Data from Vital Statistics [25]

TABLE II

DEATHS FROM ACCIDENTS 1966

Method	Total	Under 1 year	1 year	2 years	3 years	4 years	under 5 years	5-9 years	10-14 years	15-19 years
Motor vehicle non-traffic accidents	1,108	10	124	73	35	36	278	57	27	77
Other road vehicle accidents	292	-	2	-	4	5	11	35	73	33
Accidental poisoning - solid and liquid substances	2,283	53	147	85	44	16	345	23	8	75
Accidental poisoning - gases and vapors	1,648	9	7	5	4	5	30	26	42	171
Accidental falls	20,066	170	113	76	50	25	434	116	96	172
Falling on projected object or missle	1,469	5	8	14	27	16	70	57	35	81
Accident caused by machinery	2,070	-	11	21	19	22	73	69	80	138
Accident by electric current	1,025	9	14	5	7	5	40	32	44	127
Accident caused by fire, explosion of combustible materials	8,084	264	298	294	307	270	1,433	564	203	169
Accident by hot substances etc.	409	34	64	28	9	7	143	10	1	4
Accident by fire-arms	2,558	3	14	26	32	26	101	119	315	489
Inhalation and ingestion of food or other product	1,831	618	102	45	21	17	803	46	25	38
Accidental drowning	5,687	68	267	221	163	125	844	616	706	1025
All other accidents	7,001	1,462	1,193	83	66	56	1,860	224	246	284

Data from Vital Statistics [25]

CHAPTER III

EVALUATION OF POTENTIAL SUICIDE

Although it has been stated that children and adolescents always give warning of suicide, Haldane's study showed that of thirty subjects only four gave any warning of their attempt.[7] Glaser feels that many warnings may sound like "just talk" to parents since youngsters frequently use the phrase "I'LL kill myself if."[6] However, if a child, especially a very young one, repeatedly states with seriousness that he will kill himself, an attempt should be made to further evaluate the child. Glaser stresses mood changes, increased temper tantrums, changes in school performance and withdrawal or changes in attitude toward family or friends as positive evidence for serious evaluation of the child.[6] Glaser divides his suicide evaluations into several categories which are generally used but not always agreed upon concerning their prognostic value.

The first category is that of "just talk." This is the least threatening way in which a suicidal patient may announce his intent. As an example Glaser uses the following case study:

> A. B., an eleven-year-old boy, had "mentioned killing himself," according to the mother. The parents were greatly concerned about the boy's lack of friends and relatively poor school performance in the presence of very high intelligence. However, this was a constant behavior pattern with no recent change in mood, and the threat was not repeated.

> Early acceleration in the school program, social immaturity, and parental pressure for high performance had created a stressful situation. Through counseling, the parents learned to understand their role, to decrease their demands, and to foster extracurricular activities which led to better adjustment of the child in school and with his peers.[6]

The next and more serious category is that of the "gesture." The gesture is characterized by a carefully planned and executed suicidal attempt and is designed to draw the attention of a key figure in the child's life. The purpose of the gesture is to "influence that person and through him or her to control the environment."[6] The gesture is planned in such a manner as to avoid serious injury. The following example illustrates this:

> C. D., a seventeen-year-old girl told the interviewer: "I just scratched my wrist - many do." She wanted to prevent or delay her return to the parents after visiting an aunt. She was socially well adjusted, her school progress was satisfactory, and she had applied for and obtained college admission. The condition did not warrant prolonged treatment.[6]

Glaser's next category is the "threat" which must be distingished from the "just talk" category previously described. The "threat" is much more serious than "just talk" and indicates a very serious underlying problem which is not present in the "just talk" category.

> E. F., a twelve-year-old boy for whom the transfer from elementary to junior high school was an unduly stressful experience. He also felt threatened by other students whom he had reported while acting as "safety patrol" the preceding year. He refused to attend school and developed physical symptoms. In the interview he indicated that he considered suicide as "the only way out." The stress appeared overwhelming; he felt cornered, helpless, and unable to solve his conflict. On further study it became evident that the conflict was deeper. He felt different and embarrassed because of his unusual breast development, and wanted to avoid exposure during showers. The patient was removed from the stressful situation by the parents and placed in a private school where he made a good adjustment. This environmental maneuver reduced the stress of the large school, eliminated the threat by the students who knew him, and avoided exposure, since showers were not required.[6]

The last category is the "attempt." The attempts are "strong, often last and desperate warnings and involve a definite risk."[6] These attempts must be distinguished from the "gesture" by noting that they would be successful if not for intervening circumstances not under the control of the patient.

> G. H., a thirteen-year-old girl, took phenobarbital which she had available for the control of her epiliptic seizures. She left a note indicating the number of pills she was taking. By limiting the number of pills and practically leaving instructions for her rescue, she obviously did not intend to take her life, but circumstances, such as a delay in her parents' return, could have foiled the rescue.[6]

It should be noted that many authors feel that while suicidal attempts can be classified, the depth of the psychological problem and the seriousness of the intent cannot be estimated from the above categories.[9, 7]

CHAPTER IV

METHODS USED

Various methods have been employed in suicide attempts by children with differences being seen in methods by males and females. By examination of Table III, one sees that the majority of females attempted suicide by overdose of drugs while the boys tended to use more violent methods. From Table IV a study by Rosenberg and Latimer, one observes that 11 of 18 boys used violent methods while 24 of 59 girls employed violent methods. Another rather complete breakdown of methods used in suicide attempts is given in Table V by Stearns. Once again, males tended to use more violent methods such as hanging and firearms in a much greater percentage than did females. One also sees from Table V that the older the child the greater the tendency toward the use of poisons.

As was emphasized in the introduction, the methods used by children can easily be interpreted as accidents rather than deliberate suicide which makes statistical interpretation extremely difficult. Stearns explores the realm of masochistic deaths which are generally believed to be accidental deaths in the pursuit of sexual pleasure rather than suicide per se. He questions this view and while not offering any concrete evidence to the contrary states that many of these deaths are probably not accidents.[21]

TABLE III

METHOD USED

Method		Boys	Girls	Total
Drugs	Aspirin	1	2	3
	Barbiturate	1	10	11
	Combination of drugs	1	-	1
	Others	1	4	5
Self-inflicted injury				
	Wrist cutting	2	-	2
	Ligature to neck	1	2	3
Jumping				
	From window	1	1	2
	Under bus	1	-	1
Coal gas		1	-	1
Combined (coal gas and wrist cutting)		-	1	1

Data from Haldane[7]

TABLE IV

METHODS USED

Method	Male	Female
Poison	0	2
Overdose of aspirin	2	9
Overdose of sleeping pills	0	4
Overdose of other pills and liquid medicine	2	14
Taking various nonmedical liquids	2	5
Moving vehicle	0	4
Jumping from high place	1	7
Hanging	2	4
Gas	1	1
Cutting wrists	3	6
Other cutting	1	3
Smothering	1	0
Strangling	3	0
Total	18	59

Data from Rosenberg and Latimer[16]

TABLE V

METHOD BY AGE AND SEX

Method	Age of Females										Total Females		Age of males										Total males		Grand total	
	11	12	13	14	15	16	17	18	19	20	No.	%	11	12	13	14	15	16	17	18	19	20	No.	%	No.	%
Firearms	0	0	0	0	1	0	0	0	1	1	3	12.0	0	1	1	0	0	2	6	6	9	4	29	40.2	32	33.0
Poison	0	0	0	1	1	0	0	1	3	1	7	28.0	0	0	0	0	1	1	0	1	0	1	4	5.6	11	11.3
Hanging	0	0	0	0	1	0	0	0	0	0	1	4.0	3	2	1	8	3	5	2	2	1	4	31	43.0	32	33.0
Gas	0	0	0	1	0	0	1	3	5	1	11	44.0	0	0	0	0	1	0	0	1	1	1	4	5.6	15	15.5
Jumping	0	0	0	0	0	0	0	1	0	0	1	4.0	0	0	0	0	0	0	0	0	0	1	1	1.4	2	2.0
Cutting	0	0	0	0	0	0	0	0	0	1	1	4.0	0	0	0	0	0	0	0	0	0	0	0	0.0	1	1.0
Drowning	0	0	0	0	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	1	1	2	2.8	2	2.0
Crushing	0	0	0	0	0	1	0	0	0	0	1	4.0	0	0	0	0	0	0	1	0	0	0	1	1.4	2	2.0
Total	0	0	0	0	3	1	1	5	9	4	25	100.0	3	3	2	8	5	8	9	10	12	12	72	100.0	97	99.8

Data from Stearas[21]

CHAPTER V

ETIOLOGICAL FACTORS AND CHARACTERISTICS OF SUICIDE ATTEMPTS.

PRECIPITATING CIRCUMSTANCES

Haldane states that it is difficult to differentiate between precipitating event, motive and accompanying emotion.[7] A reasonable assumption is that the precipitating event is the final problem with which the child, already overburdened, cannot cope. Table VI illustrates precipitating events in a study by Haldane.[7] It is apparent that quarrels with parents or parent figures were a very important factor in suicide attempts, especially among girls.

Another study by Jacobziner is presented in Table VII.[9] This table is classified somewhat differently than Table VI, but shows that the leading reasons of suicide attempts were discipline, emotional upset, depression, and jealousy in that order.

Otto, in studying suicide attempts among Swedish school children found that 18,8 per cent of school-age children listed school problems as the precipitating cause of their attempt. These figures are presented in Table VIII.[14] This figure given by Otto differs from that given by Jacobziner (Table VII) who found that only four per cent attempted suicide for school reasons.

TABLE VI

PRECIPITANT OF SUICIDAL ATTEMPT
AGES 9 - 15

Nature	Boys	Girls	Total
Quarrel			
(a) with parents or parent figure	4	10	14
(b) with teacher	4	1	5
Anxiety about			
(a) Mother's health	-	1	1
(b) boy friend's health	-	1	1
(c) outcome of pre-court investigation	-	1	1
(d) discovery of sexual activity	1	3	4
(e) loss of male friend	1	-	1
Uncertain	-	2	2
Total	10	20	30

Data from Haldane 7

TABLE VII

REASONS FOR ATTEMPTED SUICIDE

Reason	1956	1957	1958	Total
Discipline	11	32	37	80
Emotional upset	12	13	35	60
Depression	9	18	31	58
Jealousy	9	21	11	41
School problems	-	-	14	14
Family problems	2	5	5	12
Bore illegitimate child	-	5	4	9
Drug addiction	-	1	5	6
Unknown	3	10	6	19
Total	46	105	148	299

Data from Jacobziner[9]

TABLE VIII

SCHOOL PROBLEMS PROVOKING SUICIDAL ATTEMPTS

Nature of problem	No.	Per cent
Poor school results	29	46.7
Desirous of quitting school	7	11.3
Problems with teachers and schoolmates	8	12.9
Acute situations	5	8.1
Adjustment difficulties of an unspecific nature	13	21.0
Total	62	100.0

Data from Otto[14]

To illustrate the complex background and a final precipitating event, Schrut uses the following case study:

> Miss T. was a 15-year-old whose middle-class Negro parents were striving to conform to the morality of the Caucasian community about them. The mother, a nurse, felt her daughter was "very sick" in view of her promiscuous behavior and her extreme rebellion at home. The father played a minor role in the home, continually demeaned by his wife, who lived with him "just to keep the family together." The mother sought to keep her daughter under control, threatened to take her own life, and then stated that her daughter did not deserve to live in view of her behavior, that she was "always a difficult child." Miss T.'s attempted suicide by ingestion of drugs followed a quarrel with her mother about her school attendance and her "backtalk."

Attempts among younger children usually involve more impulsive and violent methods, but almost always have a precipitating event, such as parental punishment. Otto describes a nine-year-old boy who after being scolded by his mother and punished by his father, jumped out of the fourth floor window and died.[15] Another ten-year-old boy, after constant ridiculing by his parents for enuresis, repeatedly tried to hang himself.[15] One might wonder where children learn the methods of suicide they use. Otto cites one instance in which a three-year-old boy, found unconscious with his one and one-half-year-old sister, had opened the gas cock in a closed room and explained that he wanted to kill himself and his sister because their mother had not taken them with her for a walk. Earlier in the day, the child had heard his father relate how a man had attempted to commit suicide by gas-poisoning.

HOME SITUATIONS

Almost all authorities point to an unstable home situation as a chief cause of attempted suicide. Bender and Schilder in 1937 reported six children below the age of ten years who attempted suicide repeatedly.[3] All came from unstable home environments. Bakevin states that "Most commonly the child is unloved, or he considers himself unloved, the need for affection in such cases being especially great because of a physical defect or illness or because of social deprivation."[2] The adverse home situation provokes feelings of aggression which are directed primarily against those who denied affection. Guilt feelings, engendered by the aggressive tendencies toward the parents or parent substitute, lead to the aggressive feelings being turned toward the child himself.[2] Lourie noted that the majority of the children in his study came from a cultural milieu which encouraged impulsiveness, and this provided an important stimulation for putting preoccupation with suicide into the actual attempt.[11]

Jacobs and Teicher found in their study of the effect of broken homes on adolescents that 72 per cent of the suicide attempters came from "broken homes." In their control group 53 per cent indicated a background of a "broken home."[8] They give the following explanation of the dynamics:

> Therefore, it is not parental loss in childhood per se that predisposes to depression and suicides in later life. Loss of love object is an important aspect of the process, but it must be viewed as part of a process where particular attention is paid to when it occurred and/or recurred, and not merely to its presence or absence.

> Furthermore, it seems that it is not the loss of a love object per se that is so distressing but the loss of love, i.e. the reciprocal intimacy, spontaneity, and closeness that one experiences in a "primary relationship."[8]

They point out the "love object" need not be physically absent for the child to experience "loss of love object." Their research indicates that the suicide attempter was alienated from his parents more frequently and to a greater degree than in the control group of adolescents.

Glaser points out that in his series about one-half of his cases came from homes in which the father played a very passive and disinterested role in the family.[6] He speculates that this absent father figure creates a vacuum in which the child is not afforded the support against a domineering mother thus reducing the opportunity for gaining independence. Table IX from an article by Toolan illustrates the chaotic home situations in 101 children who attempted suicide. One notes from this table that in the majority of cases at least one parent was absent, usually the father. Table X, also from Toolan's article, illustrates the absence of parents in his suicide group. Again the greatest numbers of children who attempted suicide came from families where the father had been absent. These findings support Glaser's theory on the absent father figure.

Although it is difficult to assess the extent of influence a disturbed home situation exerts on childhood suicide attempts, most authorities agree that it does play a significant role.

TABLE IX

CURRENT LIVING ARRANGEMENTS

Both parents	32
Mother	42
Father	3
Relatives	8
Foster home	3
Institution	10
Other	3
Total	101

Data from Toolan[22]

TABLE X

ABSENCE OF PARENTS (FOR MORE THAN THREE CONSECUTIVE MONTHS)

Father during 1st year	20
Father during 2nd year	9
Father after 2nd year	23
Mother during 1st year	2
Mother during 2nd year	4
Mother after 2nd year	2
Both during 1st year	7
Both during 2nd year	6
Both after 2nd year	11
Total	84

Data from Toolan[22]

DYNAMIC OBSERVATIONS:

The following description is taken from Lourie as he interprets the child's view of death from a developmental standpoint.[12] Toward the end of the child's first year, he begins to respond to separation indicating that he equates absence with nonexistence of the absent person. As he matures he gains control of this process and when angry he can turn and remove that person. Having faced separation anxiety from the mother, when she returns he may turn away from her. Implicit in the older infant's death concept is that nonexistence or death is not permanent since the person out of sight most often reappears. If the person responds to the child's turning away by hurt and rejection, the child has learned a valuable lesson concerning the gains of removing himself. The child now feels that he can initiate and control "death." From two to four years of age the child may have fantasies in which he can cause the "death"(removal) of anyone who offends him, even those he loves. About this time he begins to have fears of death himself and may equate it with damage to or loss of a bodily part. At this point death, still being seen as reversible, is associated with violence, especially at ages three and four. Lourie illustrates this with examples of literature for this age group: Jack and Jill falling, Humpty Dumpty falling, cradle falling out of the tree top etc. Simultaneously, the child's aggression and anger are beginning to be inhibited by maturation of love for the mother.

Aggression is also being displaced to others in games and in play. He notes that this essential step is missing in many of the children he has studied, especially in those situations in which the mother is unavailable or when living situations are chaotic. Fantasies of death normally occur again between the ages of three and six, and come in the form of death wishes against a loved one who might be in his way. The triangle of father, mother and child is especially involved at this age, Usually there is internalization of these wishes and the child becomes relatively more concerned about his own death at the hands of self-created images such as ghosts, giants, monsters etc. During these developmental phases, the child learns from the reaction of adults to his responses. He learns what death means in terms of controlling his environment and of achieving importance in the lives of others. Lourie emphasizes that during this period the "fusion of libidinal and aggressive drives as integrated with these concepts of death is accomplished."[12] One might apply this concept to the relationship of primary masochism and suicide, hypothesizing that the emerging sexual function may be involved in the fusion of the libidinal and aggressive drives mentioned above, and this in turn might explain the observation that masturbation is not an infrequent accompaniment of suicide in adolescent boys.

PSYCHIATRIC EVALUATION

This is one of the most difficult areas to interpret due to the variance of examiners and systems of classification. Table XI presents the findings of Toolan. His study showed that the younger children were more disturbed, the majority being schizophrenic.

Table XII presents the findings of Haldane. This differs from Toolan in a much lower incidence of schizophrenia. This difference may be due to differences in diagnostic criteria which are not given in the articles. A final table is taken from Rosenberg and Latimer who found that highest number of suicide attempts occurred in those children with a diagnosis of "personality pattern disturbance."

PERSONALITY CHARACTERISTICS

Shaw, in commenting on constitutional correlations, feels that many of the suicide attempters were children who can be classified as "intense reactors."[20] These children react to situations with heightened sensitivity. This increased sensitivity may show up in certain Rorschach and color shading responses which have been correlated with suicide attempts. These children also have a low tolerance for frustration. Suggestibility is also heightened in these children.

DEPRESSION

Depression in childhood has long been neglected for the reason that it was not thought to exist. Only in recent years has this important determinant been given attention. Children do not react to depression as do adults. Depression is often manifested in the younger child by behavioral problems. The child may feel inferior to others; denial being used to mask depressive feeling. The depressed adolescent may react with boredom, restlessness and preoccupation with trivia. He may lose interest in things, and appears to be constantly busy to ward off the boredom. He may act out with delinquency, sexual escapades or alcohol. In addition, other signs may be hypochondriasis, excessive fatigue and difficulty in concentration.

Most authors feel that the majority of their studied children exhibited these signs of depression but that they were not recognized for what they were prior to the suicide attempt.

TABLE XI

DIAGNOSES

Childhood schizophrenia	12
Schizophrenic reaction	33
Personality pattern disorder	10
Personality trait disorder	25
Transient situation reaction	2
Mental deficiency	4
Neurotic reaction	16

Data from Toolan[22]

TABLE XII

DIAGNOSES

	Boys	girls	Total
Character disorder	6	13	19
Reactive behavior disorder	1	3	4
Depressive state	3	3	6
Schizophrenia	-	1	1
Total	10	20	30

Data from Haldane[7]

TABLE XIII

PSYCHIATRIC DIAGNOSES

Diagnoses	Female	Male	Total
Transient situational personality disorder	6	2	8
Personality pattern disturbance	13	3	16
Sociopathic personality disturbance	1	2	3
Psychoneurotic disorder	4	2	6
Psychotic reaction	2	1	3
Schizophrenic reaction	4	2	6
Chronic brain syndrome	3	2	5
Mental deficiency	1	0	1
Other diagnoses	2	0	2
Undiagnosed	1	0	1

Data from Rosenberg and Latimer[16]

CHAPTER VI

PREVENTION AND TREATMENT

Prevention and treatment are inseparable components of successful therapy. The general aims of therapy are guided by the particular pyschodynamic problems and not necessarily by the specific symptom, in this case attempted suicide. When a child is presented to the physician, he must be aware of the variability of the presenting symptoms of childhood depression and seek out the cause utilizing both parents in the analysis of the family situation. The physician must know the child well to adequately evaluate the impact of conflicts and tensions upon the particular child. Since the child's problems often stem from family conflicts, every effort should be made to give the parents an understanding of their problems. Since this is frequently impossible, the child should be removed from the environment even if only temporarily. Shaw emphasizes that frequent evaluation of the child is extremely important and that during these meetings certain key signs should be looked for; pronounced or continued regression, repetition of suicidal behavior, refractory environment, and a break in communication with the patient. He recommends immediate hospitalization if these signs become present in a high-risk patient.[20]

CHAPTER VII

CONCLUSION

The problem of suicide in childhood has been examined in a review of the recent literature pertaining to this problem. The opinions and findings of these various authors has been reviewed and the pertinent findings of their research have been utilized. From the material presented in this paper, one may construct a hypothetical child who embodies the characteristics of the attempted suicide as has been described.

The child will probably be a female, either the youngest or oldest child. Her family situation will be chaotic and more than likely the father will either not be present or will play an insignificant role in the family. She will have lost interest in things and may seem constantly busy with trivia. She may also exhibit excessive fatigue and difficulty in concentration. As her problem progresses, she may threaten to kill herself, a statement which may not be taken seriously. She may attempt to kill herself and if she does attempt she will probably use an overdose of drugs as the method. In retrospect, she will be remembered as an "over-excitable child;" one who could not tolerate frustration.

The hypothetical child is presented in order to illustrate that there are common characteristics in potential suicides and that these signs must be considered serious. Prevention is the most promising aspect of childhood suicide and the awareness of physicians to the signs of the potential suicide cannot be overemphasized.

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