DOI: http://dx.doi.org/10.5915/15-4-12426

SUICIDAL CHILDREN

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Introduction

Suicide is a grave emergency in medical and psychiatric practice. When it is resorted to by those who are young and in their formative years, it becomes, in addition, deeply tragic. This article is an attempt to explore the complex set of events and circumstances that eventually culminate in this "paradox of human existence,"[1] namely the conscious repudiation of life in defiance of the most basic of biological principles.

Suicide as an act has always been with us. It has even been recognized as a problem for scientific study for a long time. Study of suicidal children, however, has attracted attention only recently.

General studies on suicide tend to minimize its significance among the young as "negligible,[36] or as "relatively rare."[49] Eissler[21] believed that children in preoedipal, oedipal and early latency period "seem to be incapable of suicide." Balser[4] definitively stated that suicide in children was not only rare but usually impulsive in nature and without preoccupation or depression. Several postulations have been forwarded to explain this apparent rarity. Chapman[10] believed that children under ten have "very vague ideas of death" and often view it as a sleep and not as an irreversible cessation of existence. Schneidman[82] attributes it to the relative rarity of death of the loved ones in young age group (as compared to the adults). Recently this "rarity" has become a subject of controversy. Toolan[95] believed that "contrary to popular opinion, suicides and suicidal attempts are not rare in childhood and adolescents." The concept that suicides do not usually occur below the age of ten years has also proved to be inaccurate. Toolan presented the case of a five year old child who first threatened self-destruction and then burned himself over a gas heater and then poured scalding water over himself. Afterward he picked at his wounds so that they did not heal properly. Morrisey[65] reported observing "death anxiety" as early as 3½ years of age. At Bellevue Hospital, in 1960, out of 900 admissions to the children's service, 102 were following suicide attempts. Most people today believe that many suicidal attempts and even suicides are concealed by parents and well meaning physicians as "accidents." Schrut[33] believed that 50% or more "attempts" were either not reported or dubbed as accidents. He noted that in New York there were probably 50 known suicidal attempts for each suicide in the age group below 20 years. This seems to be a fairly sound estimate in view of Tuckman's[96] report that in his series of suicidal attempts under the age of 18, only one in 50 succeeded in killing themselves. Shaw[87] further argued that there are perhaps several reasons for the apparent reported rarity of suicidal attempts in children. He pointed out that the method used by children may lend itself to be mistaken for an accident. Wolberg[109] addressing the same point described the case of a young man who under hypnosis recalled his first suicidal attempt at the age of 9 years. He had, "deliberately" cut his wrists with barbed wire following a quarrel with mother. It was considered, at that time both by his parents and his doctor, as an accident. Shaw also points out that children fail to communicate their suicidal intent through suicidal notes, etc. But he believed that even if the clues were available they may be denied for fear of being blamed on family upbringing. Further, the Western culture has traditionally underestimated the intensity of children's motives and emotions. Thus, the suicidal possibilities are not often investigated when children die.

Following cases will illustrate the awesomeness of responsibility and desperateness of the situation in managing a youngster who is contemplating suicide.

A., an eight year old boy, tried to choke himself with a "noose made out of his belt" immediately following a firm reminder by the staff about changing his clothes after school. At the time of attempt A. resided in a children's group-care setting with three other siblings. The placement in the group-care setting was the result of a prolonged investigation of the family situation by a social agency and the Juvenile Courts. They all felt that both parents were "alcoholic," neglected the housekeeping to the point where the home had become "indescribably filthy," fed the children inadequately and sent them to school in dirty clothes and with "odorous bodies." A sibling stayed out of the house thrice for two or three days each time, but the parents knew nothing about it because they were intoxicated.

Father was a trained technician, capable of earning $12 to $15,000 but couldn't hold any job due to alcoholism. When A. was in the institution they rarely visited him and frequently failed to keep the visiting appointments. A. would get dressed and would wait for them for hours at a stretch hoping they would come and would even miss the group activities scheduled during that time.

A. was a rather small-sized boy who wore glasses for strabismus about which he was told that he would require surgery at some future date. Nothing significant was noted in the developmental history. He had been physically healthy, did grade-level work at school and had "never" been a behavior problem at home, at school, or at the institution where he was placed. He was noted to be "extremely shy," looked down continuously when talking to anyone. He felt rejected, easily became tearful, and had a very low self image. He thought that he looked "ugly, junky and stupid." In addition, he was sensitive, avoided competive activities and became visibly enraged when he lost any game. Occasionally, in this state of rage he "struck" at peers.

In therapy he was seen as narcissistically oriented, unable to share, infantile, suspicious, and did not confide in the therapist. Initially he was tearful, depressed, withdrawn and preoccupied about going home when "my mom buys a great big house with six rooms in it." A few months later he began to "answer" some questions by the therapist without feeling threatened. But even then he remained extremely defensive. He talked about the suicide attempt explaining that the nurse "hollered" at him and when she asked him to change his clothes she sounded like she was "giving an order." He felt "mad" and "wanted to make her feel sorry." When asked about what could have happened if he was not rescued, he replied, "You mean I could have died? That is foolish. Whatever gave you that silly idea? Boy, are you odd!" It seemed as if the very idea of the possibility of death generated considerable anxiety. In fact, his attempt was so serious that when the staff rescued him his face was flushed and there were pressure marks on the neck. When asked about what is death he became incoherent and said "There ain't no such thing . . . I guess people die though . . . they go somewhere like a . . . what do you call that place where they all live under tombstones . . . cemetery, I mean." He talked so positively about the family and had such high hopes about "mom and dad stopping to drink" and buying a "great big house" and "taking us kids back," that he seemed to be talking about the family he fantasied and not the one he lived with. The denial, repression, and even conscious fantasizing were quite evident. Also he became orally dependent. He demanded candy, cold drinks or gum after each therapy hour. He constantly reminded the therapist of how other female doctors "take their kids to buy ice cream and soda pop." During the same period he became extremely hostile toward the nursing staff, bumped into the walls after "forgetting" his glasses somewhere (under the trash can or under the bed or out on the lawn)! He tried to run away and made at least two suicidal threats, once following a "quarrel with staff, he threatened to jump out of the window." On another occasion he climbed over the chinning bar in the gym and threatened to jump and kill himself unless the staff apologized for telling him "get out of the way." Within a few weeks of beginning to talk freely with the therapist he felt extremely threatened by the closeness and panicked in the office. Thereafter, he often talked about how sharp the tips of the darts were. At times he would jokingly point the darts at the therapist and would pretend to throw them at him. Then he would laugh saying "this could kill you." At this time he shunned "talking" about anything related to his problems.

He complained to the nursing staff that it was no fun to go to the doctor's office because "he talks" instead of doing things and having fun. His main preoccupation at this time was to become a "super hero" so that when he gave an order, everyone should obey saying "Yes, Superman." He never showed any guilt or remorse. On the contrary, he felt that he had done something heroic by attempting suicide. His later conversations indicated that he was very much aware that his heroic suicidal gesture had changed everything. Soon after his hospitalization the parents quit drinking, bought a house, started working, visited him frequently while hospitalized and even requested the court to return all their children home.

This case amply demonstrates that there was considerable neglect and *overt rejection* on the part of the parents. This chronic neglect not only disrupted the family but generated enormous amount of *counter-aggressive* feelings in A. His rage and hostility toward the nursing staff, peers and the therapist, yet a very positive attitude toward his own family indicated the use of repression, denial and displacement of aggressive feelings and death wishes for the parents. These defenses were brought in partly to minimize the ensuing guilt and partly to keep the life-saving fantasy of returning to the mother's "great big six room house" someday (extreme oral regression). For similiar reasons he had to depreciate himself and feel, "ugly, junky and stupid," as though justifying that he deserved it all.

The self-depreciation was also a part of directing the aggressive feelings inward, against the self and the super ego. He was quite aware that he single-handedly, like a "superman," changed everything. He was attended to, provided for, and was accepted back at home. Moreover, he changed the parents too, (they stopped drinking and started working). Thus, he not only denied death as a terminal event but through it realized the dream of attaining an extreme oral regression (return to good mother), but fantasized transformation of self into a more powerful being, a "superman" with narcissistic omnipotence. The apparent "impulsivity" of the act was not understood to be a spur of the moment acting out but as the chronically repressed rage breaking through the already fragile defenses. The elements of "you would be sorry if I die" and the wish to "end it all" were present too and were verbalized fairly early in therapy.

B. an eleven year old boy, refused to go to school on the day before hospitalization. His mother insisted. The "quarrel" enraged him so much that he scratched her face, ran into the kitchen and stabbed himself. The injury thus resulting, however, was extremely minor. In the interview before hospitalization, the mother "remembered" that about a year ago he had "cut" his arms and abdomen with a razor blade. But, as the "scratches" were superficial, she didn't "worry" about them. She was "quite fuzzy" about what precipitated the event. Three months prior to the hospitalization the boy was brought to the attention of a social agency as a behavior problem and was considered for placement in a residential group-care setting. He then threatened to kill himself and agreed instead to live with the grandparents. On the day of current attempt he was visiting the mother on a weekend. B. had a long history of physical illness. According to the mother, he was the product of a "difficult delivery" and as a baby was "quite whiny" and gave her a "rough time." He suffered from "Nephritis" and had recurrent episodes of "swelling of the face" as a young child. There was a history of "spinal meningitis" and a questionable episode of a seizure. A few times he "rolled his eyeballs upward" but didn't become unconscious. In spite of all this, the family never had a pediatrician and he was treated in "various clinics." Ever since he joined the school he was a poor achiever, repeated first grade and was placed in a special class of children with a slower learning pace than average. The family situation seemed chaotic. There was ample evidence of open hostility and quarrels between mother and the older siblings which often came to the attention of local police. B.'s two older sisters were known to be delinquent and promiscuous, they had run away with their boyfriends several times. Another sister was an asthmatic. The mother, a known alcoholic for ten years, worked on and off as a waitress. She had been arrested several times for drunkenness and was known to be promiscuous. B's father died when he was two months old. An older brother was seriously ill with a chronic and intractable disease and was hospitalized at the time of B's suicidal attempt. He died while B. was hospitalized. Two other brothers, both "slow learners" were placed in Child Welfare homes. Also, while B. was hospitalized, the mother was committed to a State Hospital by court order. The family had never actively participated in the church and had not been religious. Her latest boyfriend was described as "cruel and mean" to her and to the children.

When examined, B. looked somewhat pseudo-mature but obviously depressed, unspontaneous and frightened. He literally panicked when hospitalization was suggested. The mother, except for a very brief initial contact, refused to come and discuss the child's problems and even to give more detailed history. The observations of the nursing staff and of the therapist during hospitalization, revealed that B. was somewhat unpredictably labile in his relationships with others. At times he looked obviously depressed, tearful, blamed himself for "everything" and at other times he was agitated, assaultive and profane. His initial explanation of his suicidal attempts was that he did "the dumb thing" without thinking twice. He blamed it on impulsivity. However, as the rapport with the therapist developed, he expressed a great deal of "shame" over family situation, despair and hopelessness about the future, intense feelings of rage at father's death which he perceived as "desertion." At the same time a great deal of sympathy and wish to help were expressed toward the sick brother. At his death he verbalized "sadness, helplessness and loneliness." B. even attended his funeral. For several days he was unable to sleep and felt "upset." As he showed signs of working through the loss, the intensity of anger toward the father diminished. He thought that "in a way" his brother was "lucky" that he succeeded in gaining relief from his miseries. There was at this time a sudden surge of flippant affect, buoyant manners and interest in space and stars. The protocol of psychological tests, done during this time, revealed some signs of confusion; for example, when asked, "What does the stomach do?" he replied, "What is inside the earth?" He then explained that he thought the question referred to "the stomach of the earth." His syntax and language too showed some unusual deterioration. When asked to define "brave" he said "like there is a monster

and you get out or something" and again he defined the word "Hero" as, "like if I killed a giant, I am a hero and there was a lot of people scared." The aggressive content, revealed here, later proved to be the beginning of an aggressive acting out phase after which he "settled down" and showed steady improvement until his discharge.

The mass of information, part of which is described here, revealed ample evidence of *overt rejection* by the mother right from early infancy, preventing him from developing a feeling of security or trust in adults. Consequently he never had a meaningful relationship with anyone around him. The older female siblings were not suitable models to identify with. He tried to lean on an older brother but he was drafted into the service. The only other brother who "stayed home a lot" due to illness, died. He saw his sisters "enjoying life" and for a while wanted to be a girl. There were also some feelings that then he could be as "nasty" as his mother. This secret wish to be of a different sex was a wish to identify with the aggressor, the mother, as well as a rebellion against the father. A significant component of his suicidal attempt was acting out this wish by symbolic self castration through stabbing and scratching the abdomen. Paradoxically, there was also some element of identification with father. The suicide attempt was to desert himself and mother just like his father did. The wish to be with his father was evident while he talked about his dead brother. Soon as the initial mourning phase ended he became ecstatic to the point of being confused by gratifying the long cherished desire for reunion with father, through the dead brother. Implicit in the belief that the father lived in heaven and the brother "lived" with him was the *denial of death* as a terminal event. We did not ignore the fact that the history was highly suggestive of some degree of *organic brain damage which definitely contributed to the impulsivity.* Whether the failure of the attempt to stab was due to ambivalence or *inadequate strength* was interesting but remained unanswered.

Suicidal tendencies in children have been examined as early as 1937 and the questions that were raised then are still being asked today (Zilboorg, 1937). Why do children kill themselves, and are there any predictions that we, professionals, can use to prevent this? Many aspects of this phenomenon have been evaluated to try to detect a pattern that can be applied to clinical practice.

Statistical data has been analyzed for the past twenty-five years to discern whether this is a prevalent problem in childhood. Toolan found that in 1958, vital statistics showed only 3 cases documented for suicides under 10 years of age (Toolan, 1962).

Bakwin (1957), as well as others, have felt that these low figures could possibly be attributed to the social stigma attached to suicide. Nelson in 1978, examined the variations in reporting systems within 11 western states and found noticeable differences. (Shaffer, 1981). This investigator also found this to be the case. Only 7 states currently follow the reporting system of the National Center for Health Statistics. They are as follows: Michigan (1974); Iowa (1974); Louisiana (1975); Nebraska (1975); North Carolina (1975); Virginia (1975) and Wisconsin (1975).

Vital statistics were collected on a state-by-state basis to examine the prevalence, common method used, and to view urban areas vs. rural areas. Several states were unable to furnish current statistics as well as the National Center of Health Statistics. Others could not break down the data by age, race, sex and method used. Today's statistics still prove to be an unreliable tool in testing the prominence of suicide among children.

How do suicides even get computed into statistical data? First, it must be listed on the death certificate which can include up to three causes for death. If it is not listed primarily on the death certificate, it does not have to be tabulated as such.

Secondly, who makes this determination of whether the child died of natural causes vs. unnatural? Again, each state has different criteria. Today, the United States still has two different systems to examine suspicious deaths. They are the Coroner System vs. the Medical Examiner System. The coroner is usually an elected official who is not required to be a licensed M.D. The local sheriff or funeral director could apply for this position. The Medical Examiner System requires that he/she be a licensed pathologist, but even this system can have its shortcomings. It usually does not require a specialty in forensic medicine or have a budget that will allow the pathologist to act effectively. All suspicious deaths must be reported to the State Attorney's Office, but there are some casual factors that might be overlooked. Automobile accidents, drownings and chronic illnesses can be overlooked. One statistician I spoke with felt that the majority of car accidents involving teenagers were unreported suicides. Drownings can also miss close scrutiny if no suicide note is found. In my clinical experience, I have worked with two chronically ill adolescents who blatantly stated they wanted to die and stopped medical treatment. These cannot even be listed as suicides because they would eventually die of "life-threatening illnesses."

The family physician also plays a role in the accuracy of reporting. There is the possibility of

listing the death as accidental to protect the family of the victim.

All the above factors play a role in what is actually reported. There is no one element in the breakdown of accurate statistical data.

Tishler (1980) reported that the frequency of self-poisoning in children is 5 times that of meningitis. McIntire, et al (1980) found in an emergency room study, that only 2 out of 50 children between 6-18 years of age were accidental poisonings. It was also seen in this study that 12% of emergency visits were for attempted suicides.

For younger children, parents are usually questioned about the child's intent. Every child should be asked directly why they took the poison. In one case in the McIntire, et al Study, it was found that the mother had given the poison to the child.

Common Modalities Used

The statistical data that was examined showed a high rate of completed suicides to be by the following methods: primarily with guns; secondly by hanging or strangulation and those two were followed by drownings. In Shaffer's (1974) study in England, the most common modality was gas. Guns were only reported to be used in rural areas. This partially could be due to England's strict gun control laws. Paulson, et al (1978) found that in the younger children examined, purposeful mutilation of their bodies occurred during the attempts. The means used to end their lives were usually violent, i.e., stabbing, cutting, scalding, burning and running in front of cars.

Weissman (1974) reported that there was "an overall preponderance of females over male attempters," but it was noted that these records were gathered from psychiatric settings where women received 7½ times more private care than men (Clendine & Murphy, 1971).

Teicher (1979) found that 54% of adolescent suicide attempters had been treated for either a physical and/or mental complaint 5 years prior to attempt. Some researchers have seen this occurrence take place 3 months prior to attempt.

With attempters, the common modality used is drugs. This may be a cry for help, but one out of every 200 adolescent attempters using drugs die, McIntire, et al (1980).

Pre-Suicidal Behavior

Shaffer (1974) found that children who completed suicide were involved in a disciplinary crisis. Teicher (1979) saw that an escalation of problems was seen prior to attempt. Also, he noted that 36% of attempters in the study were not attending school. Glaser (1965) found that the child had actually given some kind of warning to important people in their environment prior to the attempt. Mattsson, et al (1969) found that 40% of his study population "had for at least one month, displayed signs of depressive illness." Also, 40% had "at least one prior suicide attempt or had threatened suicide."

Mattsson, et all (1969) found in research that "suicidal behavior was the greatest single cause for emergency referral in psychiatric outpatient clinics. Stone (1980) found that criteria should be included in an assessment for lethality of the attempt. They are: What are the patient's expectations and attitudes about the act; the degree of planning, precautions taken on not being discovered and lastly, if there was any communication with anyone prior to the act. Shaffer (1974) found that the children who gassed themselves had access to an empty house and took special measures not to be discovered. In Paulson, et al (1978) study, done at the Neuropsychiatric Institute of U.C.L.A., 35% of their 34 study cases were already with social service agencies and/or the court system. They also found that private physicians or pediatric clinics had referred these children; they interpreted this to mean that there was some awareness in the family that there were some problems. Pre-suicidal behavior can manifest itself as withdrawn antisocial behavior or can go to the opposite extreme of violent outbursts. Where do the roots of this pathology lie? To examine this aspect, the child's background must be scrutinized.

The Environmental Background of the Child

In all cases of childhood psychopathology, the child's family and environment are screened for clues. Most researchers (Paulson, et al, 1978), (Shaffer, 1974 and 1980), (McIntire, et al, 1980), (Pfeffer, 1980), (Teicher, 1979), (Bender & Schilder, 1937) have found that one or more family member has had prior contact or treatment in a clinical setting. This is also prevalent in emotionally disturbed children as well, so how does one decipher this information in screening potential victims?

Ackerly (1967) found that several of the children he studied had severely depressed or suicidal parents. This area was also examined closely by Pfeffer, et al, 1979 who conducted empirical research to examine differences of suicidal children vs. emotionally disturbed children. They found that mothers of suicidal children were significantly more depressed. Of these mothers, 22% had suicidal ideation, 17% had attempted suicide and 3% had completed suicide. Also, there were fathers that had

threatened, attempted or completed suicide. Suicidal children also saw death as temporary (Pfeffer, et al, 1979).

Ackerly (1967) found that more males were seen for suicidal tendencies prior to adolescence. These figures reverse themselves during adolescence, Pfeffer, et al (1980), on examining an outpatient population for suicidal behavior, found that boys also outnumber girls. Paulson, et al (1978) found a 2:1 ratio of males to females in this younger age group.

Pfeffer, et al (1980) found no difference in family composition between suicidal and non-suicidal children, e.g., marital difficulties, separation, parental violence and child abuse.

The majority of researchers have noted that suicidal children come from broken homes, but with the current data, this does not look like it will necessarily be a good predictor. Much attention has been focused on this aspect, but it is just a portion of the total picture.

School functioning has been studied to see if this could be a reliable predictor. Teicher (1979) found 36% of his case study were not enrolled in school at the time of the attempt. Pfeffer, et al (1979), found that 48% of the suicidal children she investigated were constantly worried about doing poorly in school vs. 19% of non-suicidal children. Shaffer (1974) found that the majority of children had average to high IQ's.

Most investigations have also shown these children to have poor peer relationships as well. This has not been identified as a reason for poor school attendance.

Pfeffer (1979, 1980) research presents a new focus on distinguishing suicidal children. There is still a great need to continue in this direction to enable professionals to deal more effectively with this phenomena in childhood.

Race

Very little has been written concerning the race of children who attempt suicide. This could be due to the inaccurate statistics on this subject. Those who have addressed this issue have done so in relationship to the cases they have examined. Mattsson, et al (1969) found that "race showed no correlation with the diagnosis, disposition in either the suicidal or non-suicidal groups. This would not be a valid detector to use to determine suicidal behavior.

Management and Treatment of the Suicidal Child

Though much has been written about screening children who display suicidal behavior, few articles focus on the treatment of suicidal children. The articles that discussed adolescents and children together had clear plans and steps to manage the suicidal adolescent. It was felt that a child attempting suicide was a sign of such severe disturbance that hospitalization should be strongly considered. With today's current funding and budget problems, hospitalization cannot be relied upon as the only alternative.

Curran (1979) delineated four steps for considering a child for inpatient treatment. They are:

1. The child who uses a seriously lethal method (guns, hanging, etc.).
2. The degree of premeditation and secrecy surrounding the attempt.
3. Children whose families are rejecting or unconcerned about the attempt.
4. Child showing signs of psychosis or severe depression.

Gould (1965), Teicher (1979), Pfeffer (1979, 1980) felt that for successful intervention to take place, it was imperative that families be involved in therapeutic treatment. All data and literature support the opinion that there must be changes in the child's environment. If this is not possible, the child stands at risk for further suicidal attempts.

These children also have a strong fascination and occupation with death and dying. They will frequently discuss this in their play sessions. Orback and Glaubman (1979) found that by realistically explaining death to the child, that it stopped their suicidal behavior. Most of these children see death as temporary or as a means of uniting them with a lost loved one.

Pfeffer (1979, 1980) found that if the child was non-verbal, by actively verbalizing your observations to them will help them facilitate their ability to verbalize their feelings.

Though much has been written about the causes of childhood suicide, few empirical studies have been done. Pfeffer (1979, 1980) and Mattsson (1969) have used their own clinical settings to collect data. Their figures would lead one to conclude that suicidal behavior is not uncommon in children as once thought. More research needs to be done along these lines as well as establishing outpatient treatment plans for these children.

Factors to Evaluate in a Suicidal Child

In the clinical evaluation of the suicidal patient, the concept of high risk could be over-emphasized because of the danger of developing the suicide stereotypes "based on averaged data," and, thus, limits the usefulness of the suicidal risk questionnaires. Nevertheless, it is useful to have a readily available inventory of various risk factors to assist in an effort to individualize an emphatic assessment of each child.

The following is such an inventory of factors emphasized as the ones increasing the risk of an attempt to be repeated:

A. Evaluation

	Recent	Past
1. The Child:	- Lack of capacity to communicate feelings. - Details of the fantasy about the act. - Refusal to recognize the need for and to accept help. - Occupied about death (wants to die) or about other important areas of functioning including sexuality. - Misperception of parental expectations or demands. - Perceives death as transient/pleasant.	- Unwilling to stand difficult situations (poor coping with skills). - Impulsive/immature/dependent personality. - Hostile/belligerent attitude. - Dangerous/destructive/reckless behavior. - Omnipotent fantasies/denial of death as final.
2. The Family:	- No living relatives - React to child's attempt: helpless/indifferent/anger/punitive. - Poor communication. - Loss.	- Large families. - Loss. - History of: suicidal tendencies/acts. - Broken/disorganized. - Unsympathetic/irresponsible/ambivalent/inconsistent/abusive. - Chronic multiple conflicts. - Alcoholism/drug abuse. - Poor health. - Mental illness: Depression/Psychosis.

3. Circumstances:

- Planned attempt/note/availability of means.
- Loss.
- Disciplinary crisis.
- Fear of exposure and ensuing shame.
- School failure/phobia.
- School: Truance/L.D.
- Past suicidal ideas/threats/attempts.
- Past psychiatric treatment.
- Alcohol/drug abuse.
- Move.

4. Illness:

- Signs of stress: Irritable/bored/lonely, restless/oversensitive/loss of interest/withdrawal, etc.
- DEPRESSION (overt/masked): sad faced/retarded movements or hyperactive/feels hopeless, helpless, empty/loss of self esteem/moody, crying spells/eating problems/sleeping problems, etc.
- SOCIOPATHY.
- Chronic physical illness.
- Lack of feeling/dysphoria.
- Run-away reactions.

5. Other Variables:

- Lethality.
- Sources of support (professional and social).

B. Treatment Principles

* Protect/support . . (Hospitalization).
* Evaluate repeat risk and strengths . . . (Evaluation).
* Involve the family in treatment.
* Psychotherapy to improve ability to communicate feelings and to help resolve conflicts.
* Treat the underlying condition — Depression and any physical illness.
* Environmental manipulation to improve the individual's or family's situation.
* Prevent repeat attempt.

References

References can be obtained from authors.

For copies:

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