SUICIDE AND SUICIDAL ATTEMPTS IN CHILDREN AND ADOLESCENTS

(Mrs.) M. F. Smith[1]

Dartmouth, N. S.

This problem is one which has received relatively little attention in the literature in recent years. Much more was written on this subject in the latter half of the 19th century and the early part of this century. This undoubtedly is because suicide in children and adolescence was a much commoner occurrence than for thirty years prior to 1895 for example, the total number of suicides in the 15-19 yr. age group in Prussia in any one year was 10X the total for any current year in the whole United States. And yet looking at current statistics it is apparent that the topic is still worthy of some consideration.

In 1958 in the United States there were 3 cases of suicide recorded in the under 10 age group; 74 in the 10-14 age group and 367 in the 15-19 age group. Although these absolute figures are not shocking they were high enough in the 15-19 age group to place suicide 5th in the leading causes of death for this category. In that year and age group it was responsible for more loss of life than any of: leukemia, renal diseases, pneumonia, tuberculosis or poliomyelitis. In the 10-14 age group it was the 13th cause of mortality and would be comparable in incidence to deaths from appendicitis, meningococeal disease, diabetes, tuberculosis and appendicitis. Although the incidence of suicide in these age groups has decreased, it has become statistically more prominent because of a decreased mortality from infectious diseases.

In considering the significance of these statistics, it must be realized that these figures are probably lower than the actual incidence of suicide. Sometimes, especially if any doubt exists, deaths due to self-destruction may be recorded under other categories, e.g. accidents, by a kind doctor wishing to spare the parents a burden of guilt On the other hand, there is the feeling that some accidents, notably motor accidents may occur when an adolescent is deliberately flaunting danger because of a lost desire for living.

There are few references to this particular problem in Canada. The mortality per 100,000 from suicide in the 15-19 yr. group in the early 50's in Canada was 3.8 male and 0.7 female. Corresponding figures for a number of other countries are: -

U.S.	**3.9 Male**	**1.6 Female**
Japan	**26.1 Male**	**18.7 Female**
Ger. Fed. Rep.	**12.1 Male**	**6.8 Female**
Ireland	**0.6 Male**	**1.1 Female**

From these figures it may be seen that there is considerable variation from country to country in the incidence of suicide in this particular age group; in Japan, it is quite high and in Ireland quite low. In general European countries tend to have a fairly high rate whereas in North America it is comparatively low.

A little should be said about the epidemiology of suicide. It is about 2-3 times as common in males as females. In males the suicide rate increases with age as it also does in females. However, at age 60, the incidence starts to fall off. Suicide is commoner in whites than non-whites, commoner in high economic groups than middle or low; commoner in urban populations than rural communities. Suicide will vary in incidence corresponding to the regard this particular act is awarded by a culture. In Japan suicide is thought to be a noble way of dying and the incidence is correspondingly high. In North America where it is regarded as an act of cowardice the incidence is low. There is a seasonal variation in incidence of suicidal attempts. Maximal incidence is between May and July with a subsequent fall off until the lowest point is reached in

[1]5th Year Medicine, Dalhousie University.

December. The commonest methods used in attempting suicide are fire-arms and explosives: next, hanging and strangulation in boys and poisoning in girls. The commonest substances used in poisonings are aspirin, barbiturates and tranquillizers - the frequency of use is undoubtedly related to the availability and accessibility of these substances in the household. Of interest to this particular group is the fact that, over a 30 year period in Yale, suicide was the second commonest cause of death. This was the only cause higher than predicted in a group which had a lower mortality than people not in colleges in the same age group. Finally, there is the supposed lower incidence of suicide in Catholics. In Ireland, there is a very low incidence; however, it is considerably higher in France. Also in New York in a study by J. M. Toolan and in another by Jacobinizer there was a much higher incidence of attempted suicide in Puerto Ricans than in the rest of the population and this is a distinctly Catholic group.

This reference brings up the subject of suicidal attempts - the study of which has been a common means used to elicit information regarding suicide. The incidence of attempted suicide has increased over the years. U.S. suicidal attempts greatly outnumbered fatalities from suicide: estimates range from 50-120:1. This ratio is considerably greater than that estimated for the adult population where it is felt to be 3:1. Females are 10X more likely to flirt with death and are much more likely to do so in their youth. Males, on the other hand, make very few attempts until they reach the age of 65. After this the incidence increases. Adolescent female attempts at suicide account for 12% of all such acts. Attempted suicide is more common in the middle or low income groups.

Suicide is an abnormal type of short circuit reaction by a person in distress. In adults this is seen in depression especially in the affective disorders. The underlying pathology in younger people however, does not appear to belong to this group. A clearly predominant type of disease has not been uncovered. The way in which current writers have attempted to assess this factor is to study groups of children and adolescents who have attempted suicide. It has been previously mentioned that there are some differences between youths committing and those attempting suicide. It is best therefore to be reserved in applying the results of studies of this nature to suicide.

James M. Toolan reviewing their statistics at Bellvue for 1960 found that the largest group admitted for suicidal attempts was composed of character and behaviour disorders. However, the younger children were generally branded more seriously ill, the majority being diagnosed as schizophrenic. Toolan also felt that the idea that depression does not occur in the young to be falsely based. He feels that depression occurs but that the symptoms are different from those in adults. In latency, child behaviour problems, e.g. truancy, running away from home, accident proneness and disobedience can often indicate depression. The adolescent may exhibit depression by boredom, preoccupation with trivia, losing interest while frantically seeking something new to interest him or inability to stay home. Other symptoms are excess fatigue, hypochondriacal preoccupations, difficulty in concentration.

In 1959, Balser and Mastersow at the Payne Whitney Clinic were investigating the total problem of suicidal drive in adolescents. Of 400 psychiatric patients studied, a total of 37 attempted suicide. The predominant psychopathology of this group was schizophrenia - paranoid and catatonic. In many of these patients there were depressive trends, although not necessarily always present or obvious.

A striking thing that these and a few other studies revealed was that the crisis or precipitating event in many attempted suicides is usually a commonplace source of conflict for adolescents. Of particular note are quarrels over home responsibilities, keeping of hours, homework, and personal appearance. In some other cases, difficulties with the opposite sex were implicated and these increased in frequency with increasing age. Attempts have been made to uncover factors which predispose to the use of suicide as a means of resolving conflicts which most young people deal with in a more effective manner. In studies by Tuckman and Connor, and Batchelor and Napier, a correlation between attempted suicide and family disorganization was made. The families of most attempters tended to present multiple social problems. Additionally, a history of

delinquency was a common finding in the past history of these individuals and their siblings. In a study conducted by Toolan it was found that less than 1/3 of his patients were living with both parents at the time of their admission for attempted suicide. Frequently the father was reported as the absent member of the family. Absence of parental home figures and significant degrees of family disintegration are probable concomitants of emotional deprivation. Failure to receive adequate love and protection is probably significant in the pathogenesis of suicidal attempts. Feelings of aggression in most also have a role in view of the predominance of previous delinquent behaviour. One way to correlate these findings is to first suppose that for one reason or another the child is rejected by his parents. The child naturally enough, because of his dependence on them, is unable to accept this. Consequently, he denies his rejection and represses the feelings of hostility that have been generated. As he grows older he is unable to completely disregard the attitude of his parents and so may come to reason that they do not like him because he is bad - is a less painful idea than the actual fact. The hostility which has been repressed may be released in delinquent behaviour. As he gets older he may appreciate what the situation actually is but may be still unable to express his feelings adequately. He may develop guilt feelings about his hostility toward his parents. Much of this hostility may be directed inward at their introjections within his mind. This latter phase may be what precipitates depression and suicide. The gradual evolution of this picture, as proposed here, would certainly fit with the clinical finding that suicide is commoner in adolescence, especially late adolescence, than in the younger years.

Another point in this regard is that the children under 10 have an incomplete notion of death, think of it as being reversible, and fail to relate it to themselves. When depressed, they are much more likely to run away. However, attempted suicide has been reported in the young. Redlich and Lazar in 1914 reported a case in which a 3 yr. old boy and his $1\frac{1}{2}$ yr. old sister were found unconscious in a gas-filled room with the gas-jet left open. The children were revived with great difficulty. Later the boy offered the explanation that he had wanted to kill himself because his mother had refused to take him for a walk. Earlier in the day he had heard his father relate an episode about a young man who had killed himself with gas. Another case is that of a $5\frac{1}{2}$ year old boy who was scolded early in the day. At noontime he brought lunch to his father and on returning he deposited his lunch-pail on a bridge and himself in the river. This boy had told his mother repeatedly that he was unhappy and would jump into the water.

Many suicides are attempted with the knowledge that a lot is being left up to chance. The attempter is willing to gamble with his life because he feels that he will gain something by this act. If suicide is successful the individual has removed himself from an unpleasant situation. If he is unsuccessful he probably will still have aired the situation and improved things at least temporarily. A number of specific motives for suicide may be found. Anger which is internalized may drive a child or adolescent to suicide. Attempts to manipulate, to gain love and affection, or to punish another may be the motivating factors. Occasionally, it is a signal of distress as in the case of a 16 year-old girl who because of certain symptoms was afraid she was going crazy. As a result, she attempted to take her life but left a note dictating that she be brought to a mental hospital if she survived. In some cases, the drive may be psychotic and a response to inner hallucinatory commands as in the case of a 17 year old boy who took poison to corroborate that he was indestructible - a piece of information communicated to him by voices.

In summary, suicide though rare under 10 is a significant cause of death in the 10-19 age group. Suicidal attempts grossly outnumber the fatal acts and are considerably more common in young females. The use of fire-arms and explosives, hanging, strangulation and poisons are the commonest methods employed. The affective disorders are not commonly seen in the young but depression and depressive trends probably precede self destructive actions. The underlying pathology is probably a behaviour of character disorder but schizophrenia is not infrequent especially in younger children. Commoner, and more generally substantiated findings in the history of suicidal actions

are those of broken homes and delinquency. Illness of psychotic proportion is felt to be of less significance than in adults. The individual attempting suicide is frequently risking his life in the hope of alleviating a stressful situation. No attempt has been made to discuss the therapeutic aspects of this problem.

Reprinted
From an address to A.O.A., Halifax, N. S.
