Suicidal behavior and depression in children and adolescents

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The Children's Depression Inventory (CDI) and semistructured interview were used to study suicidal ideation, suicide attempt, depression as a syndrome, and diagnosis in 102 psychiatrically referred children and adolescents. We found that severe suicidal ideation increased around puberty and correlated with increasingly severe depression. Suicide attempts were more variable and did not reflect a continuum of suicidal ideation. While most youngsters who felt suicidal felt depressed, those that did not had nonaffective diagnoses. Similarly, youngsters whose suicide attempt did not lead to psychiatric hospitalization felt less depressed and met criteria for nondepressive diagnoses. Hopelessness, chronicity of psychiatric disorders, and family history of psychopathology are also explored. Journal of the American Academy of Child Psychiatry, 21, 4:361-368, 1982.

Suicidal ideation and attempted suicide are frequent presenting problems in both adult and child psychiatric facilities (Mattsson et al., 1969; Pfeffer et al., 1979). The magnitude of this public health problem and the morbidity and mortality that results from the feeling that life is not worth living have stimulated a sizable and growing body of research (Institute for Studies of Destructive Behaviors, 1980; Seiden, 1968). The rapidly increasing rate of completed suicide (Holinger, 1978; Seiden, 1968) and attempted suicide in young people (Weissman, 1974) increases our need to understand the antecedents of suicide and the relationship among suicidal ideation, suicide attempts, and completed suicide.

In adults, depression is felt to be a strong contributing factor to both completed (Guze and Robins, 1970; Miles, 1977) and attempted suicide (Goldney and Pilowsky, 1980). Of those people who commit suicide, approximately 50% suffer from serious depressive disorder. The remaining 50% are either alcoholic (25%), schizophrenic (10%), or have assorted other psychopathology. Rarely do people without psychiatric disorder commit suicide. Depression is also the most frequently diagnosed clinical condition in suicide attemptors though the occurrence varies considerably according to the study (Goldney and Pilowsky, 1980; Weissman, 1974) and according to whether depression is assessed by rating scales or specific diagnostic criteria (Weissman and Myers, 1978). (In some studies the distinction between true depressive disorder and depressive symptoms is not clear.)

In one of the few studies of completed suicide in teenagers (ages 10 to 14) Shaffer (1974) found no suicides under age 12, and an increase with chronologic age thereafter. Of the 31 children who killed themselves over the 6 years studied there were only 4 in whom psychiatric symptoms were not reported. The majority (57%) had "mixed antisocial, emotional/affective" symptoms; specifically, 13 children were noted to have "depressed mood or fearfulness." Since Shaffer was unable to interview surviving relatives, the symptoms, extracted as they were from official records, may reflect an underestimate of psychiatric symptoms in general and depression in particular.

The frequency of suicide attempts also increases with chronologic age with a rapid rise at ages 13 to 14 (Mattsson et al., 1969; Otto, 1971). Depression is cited both descriptively (Otto, 1964; Toolan, 1975) and diagnostically (Pfeffer et al., 1979) as present in many young suicide attemptors.

The relationship between depression and suicidal behavior is complex. While many young suicide attemptors and completers are probably depressed, the converse is not true. Moreover, it is unclear whether these "depressed" youngsters have a major affective disorder or are overwhelmed with the unhappiness of often untenable psychosocial situations.

This study investigates the relationship between depression and suicidal behavior by examining (1) the extent to which psychiatrically referred children who contemplate suicide are depressed; (2) if children who actually attempt suicide are more depressed than those who simply think about it; (3) which specific psychiatric diagnoses are most associated with suicide behavior; (4) whether feelings of hopelessness, chronicity of problems, or family history of depression are positively related to suicidal ideation and/or attempt; and (5) the relationship of age to the foregoing.

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361
Method

As part of a larger study of depressive disorder and depressive symptomatology in a randomly selected child and adolescent psychiatric population, 102 consenting children and their parents were systematically interviewed separately. The details of the selection process are reviewed elsewhere (Carlson and Cantwell, 1979, 1980a, 1980b). The interview, based on the Rutter-Graham interview (1968), was modified to enable diagnosis by DSM-III criteria (APA, 1978 draft). To assess depressive disorder both parent and child were asked specifically about the child’s mood, self-esteem, ability to experience pleasure, concentration, irritability, somatic, appetite and sleep problems, suicide ideation, feelings of self-blame and attitude toward the future. A global rating of severity of depression was made (from 1 = depression absent to 5 = depression severe) based on both parent and child interview. The child was considered to have an acute psychiatric disturbance if there was a clear onset of symptoms within 2 years of the interview. A chronic disorder was defined by lack of clear onset of symptoms and by a duration longer than 2 years. This methodology has been reviewed in detail elsewhere (Carlson and Cantwell, 1979, 1980a, 1980b).

Prior to being interviewed and with the interviewer blind to the results, the child completed the Children’s Depression Inventory (CDI) (Kovacs and Beck, 1977), Kovacs’ first modification of the Beck Depression Inventory (BDI) (Beck et al, 1961) for adults. In this 21-item self rating scale covering affective, cognitive, psychomotor and vegetative aspects of depression, scores of 1 to 15 were considered indicative of absent to mild depression, 16 to 23 of increasingly severe depression, and ≥24 of severe depression.

For this study we specifically examined the subject’s suicidal ideation and feelings of hopelessness based on both interview and CDI response. Toward the end of the depression questions the child was asked: (1) if he had ever felt so depressed or miserable he wished he could disappear or (2) that he wished he were dead, (3) if he had thought seriously about killing himself, and (4) if he had ever tried to kill himself. Subjects responding positively were asked for specific details about the circumstances which provoked such feelings or actions, the suicidal means contemplated, and if the feelings were in the context of other symptoms of depression. Feelings of hopelessness were ascertained by asking the child if the future looked bright or hopeful to him and if he felt there was any solution to his problems.

On the CDI, the suicide item reads: 0 = I do not think about killing myself, 1 = I think about killing myself but would not do it, 2 = I would like to kill myself, and 3 = I would kill myself for sure if I had the chance. The hopelessness item notes: 0 = things will work out O.K. for me, 1 = I am not sure if things will work out O.K. for me, 2 = I think that nothing will work out for me, and 3 = nothing will work out for me and things will never get better.

Finally, a systematic family history of psychiatric disorder was obtained from the parent(s) following the format of the Family History Research Diagnostic Criteria (Andreasen et al., 1977). Family history data were recorded as follows: If any of the subjects’ parents, grandparents, sibs, aunts or uncles had a history of major depression, the family was considered positive for depression. If there was a history of both depression and either alcoholism or sociopathy, the family was recorded as positive for depressive spectrum disorders (Winokur et al., 1971). Where family history was recorded as unobtainable or information was insufficient to make a diagnosis, the family history was recorded as “unknown” or “undiagnosed” respectively. Suicidal behavior in family members was recorded apart from diagnosis. “No psychiatric disorder” was noted only when a thorough history was obtainable on family members and no psychopathology was present.

We examined demographic, depressive and diagnostic characteristics of children with increasingly severe suicidal ideation by creating four groups. Group A consisted of children who denied suicidal ideation on both CDI and interview; group B denied suicidal ideation on CDI but admitted to such thoughts on interview. When suicidal ideation based on CDI response alone is examined, groups A and B are combined. Group C children noted “I think about killing myself but would not do it” on CDI and admitted to such on interview. When the presence of any mild suicidal ideation is examined, groups B and C are combined. Group D children rated themselves on CDI as severely suicidal (choosing items 2 or 3) and also described those feelings on interview.

Suicide attempters fell into two obvious groups: (1) those whose attempt had led to hospitalization either because of medical seriousness (N = 3) or because parents or doctor felt concern about the subject’s future suicide risk (N = 8) and (2) those whose psychiatric referral or hospitalization was for problems other than concern about suicide potential (N = 11). The chi square test and Student’s t-test were used for statistical analyses.

Results

Data collected in our study are shown in table 1.

Suicidal Ideation

Forty-five percent of the total sample, group A,
**TABLE 1**

**Suicidal Ideation, Depression, and Demographic Variables**

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Mean Age (yr)</th>
<th>% Hospitalized</th>
<th>Mean Total CDI Score*</th>
<th>Mean Interview Depression Score</th>
<th>Subjects with Depressive Disorder*</th>
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</thead>
<tbody>
<tr>
<td><strong>Suicidal Ideation</strong></td>
<td></td>
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<tr>
<td>Total group</td>
<td>102</td>
<td>12.6 ± 2.9</td>
<td>55</td>
<td>14.7 ± 10.2</td>
<td>2.4 ± 1.6</td>
<td>1° Dep—14</td>
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<td></td>
<td>62</td>
<td>M</td>
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<td></td>
<td>40</td>
<td>F</td>
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<tr>
<td>A— &quot;I do not think about killing myself&quot;</td>
<td>45</td>
<td>11.9 ± 2.4</td>
<td>38</td>
<td>10.4 ± 7.0</td>
<td>1.7 ± 1.0</td>
<td>1° Dep—3</td>
</tr>
<tr>
<td>0 on CDI</td>
<td></td>
<td>(17 ≥ 13 yr)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A— &quot;I think about killing myself but would not do it&quot;</td>
<td>10</td>
<td>13.3 ± 8.4</td>
<td>60</td>
<td>12.3 ± 9.7</td>
<td>2.8 ± 0.9</td>
<td>1° Dep—1</td>
</tr>
<tr>
<td>1 on CDI</td>
<td>4</td>
<td>M</td>
<td>(7 ≥ 13 yr)</td>
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<td></td>
<td>6</td>
<td>F</td>
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<tr>
<td>D— &quot;I would like to kill myself&quot; and &quot;I would kill myself for sure if I had the chance&quot;</td>
<td>12</td>
<td>14.0 ± 2.7</td>
<td>100</td>
<td>24.4 ± 9.6</td>
<td>3.9 ± 1.0</td>
<td>1° Dep—3</td>
</tr>
<tr>
<td>1 on CDI</td>
<td>7</td>
<td>M</td>
<td>(8 ≥ 13 yr)</td>
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<td>5</td>
<td>F</td>
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<tr>
<td><strong>Suicide Attempt</strong></td>
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<td></td>
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<tr>
<td>Nonhospitalized (for attempt) suicide attempters</td>
<td>11</td>
<td>14.4 ± 1.9</td>
<td>82</td>
<td>13.9 ± 5.6</td>
<td>2.3 ± 0.9</td>
<td>1° Dep—1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>M</td>
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<td>6</td>
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<tr>
<td>Hospitalized suicide attempters</td>
<td>11</td>
<td>13.7 ± 3.3</td>
<td>100</td>
<td>23.2 ± 15.1</td>
<td>3.8 ± 1.1</td>
<td>1° Dep—5</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>M</td>
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<td></td>
<td>8</td>
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</table>

* Suicide item was subtracted in: obtaining mean total Children’s Depression Inventory (CDI) score.

1° Dep = primary depression; 2° Dep = secondary depression (Carlson and Cantwell, 1980b).
and C. Eight of 12 subjects had families with either depression (N = 3), depressive spectrum disorders (N = 4), or alcoholism alone (N = 1). There were 2 subjects with family members who had made suicide attempts and no family was recorded as without psychiatric disorder.

Of the 28 subjects with suicidal ideation and CDI scores >16, 20 met criteria for depressive disorders. However, of the 18 children who reported thinking about suicide but had low depression (CDI) scores (less than 16), 10 had behavior disorders, 2 were schizophrenic, only 3 had depressive disorders, 1 had anorexia nervosa, and 1 overanxious disorder. Finally, 15 depressed (on CDI) children who denied suicidal ideation on CDI contained only 2 who met criteria for depressive disorder. The majority were schizophrenic, followed by those with behavior disorders, anxiety disorders, and anorexia nervosa.

When children 7 to 12 years were compared with those 13 to 17 years, it appeared that over half of the young children (53%) denied any suicidal ideation vs. 35% of adolescents (p = 0.07 by χ²). Conversely, 16% of adolescents admitted to severe suicidal ideation vs. 6% of young children (p = 0.08). There were no significant differences between younger children and adolescents in the slight suicidal ideation category, in chronicity of psychiatric illness, feelings of hopelessness, mean CDI score, or diagnosis of depressive disorder.

Chronicity of psychiatric disorder had no particular bearing on the intensity of suicidal ideation; 66% of nonsuicidal and 42% of severely suicidal youngsters were “chronically” psychiatrically disturbed (p > 0.05).

Only 20% of the 102 children endorsed the hopelessness item on CDI, while 44% admitted to such feelings on interview. However, 75% of group D children reported feeling hopeless on interview in contrast to 31% of group A (p < 0.01) and 50% of children in groups B and C. Five of 12 group D children endorsed scores of either 2 or 3 on the CDI hopelessness item in contrast to 3 children in the remaining population (p < 0.001). Finally, children with depressive disorders were twice as likely to feel hopeless as children with all other diagnoses (67% vs. 35% p < 0.005).

Suicide Attempts

Of the 102 interviewed subjects, 22 admitted to having made a suicide attempt. Significantly more were adolescents (17 vs. 5 < 13 years; p < 0.005 by chi square). Eleven of these subjects had been hospitalized for the attempt for either medical or psychiatric reasons. In the other 11 cases the “attempt” was part of the psychopathology of the present illness, but psychiatric referral was not a consequence of the attempt per se. Taken together the mean CDI score for the attempters was 18.6 ± 10.4. Of youngsters scoring in the depressed range (≥16) on CDI 30% had made suicide attempts in contrast to the 18% of subjects with CDI scores below 16 (p < 0.07).

Beyond the criteria of hospitalization, no effort was made to gauge lethality of the attempt. Among the 5 preteen children (mean age 10 years), suicide attempts consisted of skateboarding in a busy intersection hoping to be hit, taking aspirin, banging the head against a bedroom wall, jumping off the roof of the house, and self-immolation. All attempts were poorly conceived and executed, but the seriousness of the children describing their wishes to die was impressive.

Among the 17 adolescents, the seriousness of the attempt varied considerably. One girl had swallowed lye necessitating reconstructive esophageal surgery; of 2 girls with bipolar affective disorder one swallowed gasoline, the other tried to hang herself when no one was at home. Of other adolescents who “overdosed,” one swallowed 1 lithium pill; another took an anticoagulant and cut herself. Other pills taken included seizure medications, mother’s antidepressants, “one of everything in the medicine cabinet,” an assortment of sleeping pills, and aspirin. One boarding school youngster had been coincidentally found with a gun hidden under his bed which he had intended to use on himself; an unrelated drug search of the boy’s room uncovered the plan.

The 11 youngsters hospitalized as a result of their suicide attempt were more depressed on interview (p < 0.02) and CDI (p < 0.07) than nonhospitalized attempters. Eight of 11 hospitalized attempters met criteria for major affective disorder in contrast to 3/11 nonhospitalized attempters (p < 0.05).

Of suicide attempters, 50% had families with either pure depression or depression and other psychopathology, 59% if alcoholism is included. This compares with 31% of nonattempters (50% including families with alcoholism) and is not statistically significant. Among hospitalized attempters, 9/11 had families with depression (4), depressive spectrum (3), or alcoholic (2) disorders. There was 1 suicide. Four of 11 nonhospitalized attempters had depression or depressive spectrum disorders in their families.

Some 49% of nonattempters vs. 59% of attempters were found to have chronic psychiatric disorders while 38% of nonattempters vs. 50% of attempters admitted to feeling hopeless on interview. Neither was statistically significant.

The relationship between suicidal ideation and suicide attempt is pictured in figure 1. Of those youngsters expressing severe suicidal ideation (group D) 42%
had made a suicide attempt in contrast to 34% of those with slight suicidal ideation (groups B and C); this was not significantly different. There were 2 attempters in group A. Although numbers are too small for a valid $\chi^2$ test, there is a trend suggesting more hospitalized attempters are in the seriously suicidal group ($p = 0.07$) than the slightly suicidal group.

**Discussion**

In trying to explore some reasons why some psychiatrically referred children contemplated or attempted suicide and others did not, we have examined: (1) children’s feelings of hopelessness, (2) duration of psychiatric illness, (3) feelings of depression, (4) psychiatric diagnoses, (5) family history of psychopathology, and (6) the relationship of age to the foregoing variables.

A positive association between suicidal ideation/attempt and hopelessness has been reported in adults (Beck et al., 1975). Our findings are surprising in that feelings of hopelessness were not described in more of the suicidal children, and that these feelings did not distinguish attempters from nonattempters. Moreover, younger children reported feelings of hopelessness as often as adolescents so that feelings of hopelessness per se did not explain the increased suicide attempts in adolescence. It is possible our findings might have been different, however, had we pursued feelings of hopelessness with the more elaborate instrument used by Beck et al. (1975).

Although we hypothesized that children with more chronic problems would feel more desperate and have fewer coping skills, it did not appear that duration of psychopathology as we defined it played a part in suicidal behavior.

As can be seen from table 1 and figure 1 there is a direct association between feeling depressed (as reported by CDI and interview) and feeling suicidal. We have found that 63% of subjects with depressed CDI scores are suicidal vs. 34% who are suicidal but not depressed. Others who have studied suicidal ideation (as opposed to attempted or completed suicide) in conjunction with depression inventories have also found this association. For instance, in a general adult population study of suicidal ideation using a depression scale called the CES-D, Vandivort and Locke (1979) found that 23% of over 3700 subjects with high depression scores were suicidal in contrast to 4% of those with low depression scores ($p < 0.001$). An even better correlation was found in adult psychiatric patients where Beck, using the Beck Depression Inventory found 74% of those with “depressed” scores had suicidal wishes vs. 12% of nondepressed patients (Beck, 1967).

Considerably more has been written about the association between suicide attempt and depression. A consensus of studies recently reviewed by Goldney and Pilowsky (1980) reports that 50 to 75% of suicide attempters are found to be depressed. Although most discussions focus on the presence of depression in subjects feeling suicidal or making attempts, we were impressed with the clinically significant percentage of persons who feel suicidal without reporting depression (41% of Vandivort’s subjects) or who make attempts without feeling depressed (Goldney and Pilowsky, 1980). In our study, CDI-depressed youngsters who made attempts were barely more common ($p = 0.07$) than those with CDI scores less than 16.

An examination of the psychiatric diagnoses made on our subjects may shed some light on both the association between depression and suicidal behavior and lack of same. In our sample 71% of subjects with suicidal ideation and high depression scores on CDI met criteria for depressive disorders. The majority of those with suicidal ideation but low depression scores had behavior disorder diagnoses and only 3 had depressive disorders. Conversely, children with high depression scores but no suicidal ideation had schizophrenia or behavior disorders and only 2 met criteria for depressive disorder. These data are similar to findings of Silver et al. (1971) of suicide attempters. Those with affective disorder diagnoses had the highest suicide intent scores followed by those with personality disorders, alcoholism, and schizophrenia. To summarize, among subjects with suicidal ideation,
children with depressed (≥16) CDI scores had depressive disorder diagnosed most frequently. Where there was a disparity between suicidal ideation and the CDI score, other diagnoses were more common.

A review of diagnoses made on children who made actual attempts reveals that most of the children whose attempts led to hospitalization met criteria for affective disorder. In fact, except for the three hospitalizations for medically serious attempts (swallowing lye, gasoline, anticoagulants) it was probably the suicide attempt in an apparently depressed youngster that prompted psychiatric hospitalization. The majority of children psychiatrically referred for other reasons met criteria for psychiatric disorders other than depression. These children were not only less depressed on admission, but they also denied pervasive depressive symptoms at the time of the attempt. Parents often did not know of their children's attempts or disregarded them except as manifestations of their general “bad” behavior which in and of itself was usually serious enough to prompt inpatient referral. McIntire et al. (1977) have reported similar findings in a study of adolescent attempters. Those with low lethality of intent were found to be more hostile, less depressed, and more likely to have a history of antisocial behavior.

The magnitude and pervasiveness of psychopathology in both first and second degree relatives of all of our subjects was impressive. Unfortunately, our family history data contain too many family members with psychopathology unknown to permit unequivocal conclusions. (This is the rationale for recording total known family psychopathology.) We feel it is clinically, if not statistically, significant that the rate of reported depressive phenomenology increases across increasingly suicidal youngsters and that the number of subjects with family members reporting no psychiatric disorder decreases. Given both the known association between family turmoil and suicidal behavior in young people (Barter et al., 1968; McIntire et al., 1977; Otto, 1964; Tuckman and Cannon, 1962), and the hereditary aspects of major depressive disorder (Winokur et al., 1971), genetic and environmental contributions are surmisable from our data. Further study is obviously indicated. It is also interesting, however, that there is considerably less correlation between family history and actual suicide attempt. Moreover, while the overall frequency of reported suicidal behavior in family members is low, 2 of 3 known suicides took place in families of subjects reporting no suicidal ideation or depression. Again it appears that suicide attempts do not necessarily reflect a severity spectrum of depressive psychopathology.

Finally, the impact of adolescence on depression, suicidal ideation and suicide attempt in this psychiatric population is not clear. Although general population studies (Rutter et al., 1976) find that depression increases in adolescence, we found no statistically significant differences in depression measured either by CDI score or DSM-III diagnosis. Not only is a psychiatric population different from the general population, it is also likely that the population of children referred to UCLA-Neuropsychiatric Institute is more disturbed than the children seen in outpatient clinics or private practice. Hence the generalizability of this observation may be limited.

We did find that the frequency and intensity of suicidal ideation increased with chronologic age. This is not surprising given the rise of both suicide attempt (Otto, 1971) and completed suicide (Shaffer, 1974) with increasing age especially after puberty. When we specifically compared younger children with adolescents regarding the absence of suicidal ideation or the presence of severe suicidal ideation, however, the relationship was only slightly significant statistically. Suicide attempts were clearly a more adolescent phenomenon. Thus, the uncertain relationship among depression, suicidal ideation, and attempt is not made any clearer in the teenage years.

What accounts for the disparity between suicidal feelings and depression in some of our subjects?

1. They are not telling the truth. We have discussed elsewhere that the CDI, like most such instruments, diagnoses more subjects as depressed than is found on interview (Carlson and Cantwell, 1979). Regarding suicidal ideation, 10% denied such on CDI and then admitted to such at interview; only 2% did the opposite. (As the interviewer was blind to the CDI at interview, resolving the disparity was not possible). Given the concordance between interview and CDI, the fact that suicidal ruminations are readily admitted by suicidal adults, and the growing literature that supports the fact that children are reliable reporters of their internal affective states (Puig-Antich, 1980), we have every reason to believe most of our subjects were being truthful in recounting their suicidal feelings. Thus we feel inconsistencies among depression, suicidal ideation, and attempt are only occasionally due to patient denial.

2. The suicide attempt brought the subject some relief from both the suicidal urge and the depression (this has been reported clinically) or the depressive episode remitted. As this was not a study of suicide attempts, we did not interview subjects immediately after the attempt. During the interview, however, subjects were questioned about depressive symptoms in the past and in the context of the suicide attempt. In only 1 teenage girl was it clear that her depression had
remitted and with it the suicidal ideation and reason for her attempt. We would have to assume that other youngsters not only no longer felt depressed after their attempt, but also forgot or repressed their feelings prior to the event. This, too, is possible though we doubt this explains all children who make suicide attempts but deny depression.

3. The wish to die evolves from feelings other than depression. A discussion of the theories explaining suicidal behavior are beyond the scope of this paper. Besides depression, hostility/aggression and escape from intolerable situations are the most frequently reported motivations in child and adolescent suicidal behavior (Cazzullo et al., 1968; McIntire et al., 1977; Toolan, 1975). While we did not systematically study these motivations, it is our clinical impression that they are not mutually exclusive. Clearly, further research is necessary to examine the interaction between psychiatric diagnosis and intrapsychic and psychosocial motivations.

We conclude from our findings that the relationship of suicidal ideation, depression, and depressive disorder is clearer than that between suicide attempt and depression. Suicidal ideation is perhaps a barometer of the severity of depression in many young people regardless of age. As is true for adults, seriously depressed and suicidal adolescents especially are at risk for making a suicide attempt and, in our population, these youngsters were taken seriously and hospitalized.

More enigmatic, however, are young people who feel suicidal but do not admit to feeling depressed and who meet criteria for other psychiatric disorders. Their suicide attempts may be as serious but are more difficult to predict possibly because the impulse is more transient than in people with depressive disorders. There seems to be increasing evidence that dismissing as not serious these attempters with the pejorative terms of hysterical, impulse disorder or the like is wrong (Goldnay, 1981). On the other hand, expecting to diminish the suicide risk of this segment of the population by diagnosing and treating their “depression” is also likely to be unrewarding. Paykel et al. (1974) concluded that for adults “a whole host of factors, such as cultural prohibitions, impulse control and social support may intervene between the suicidal thought and the act.” It is likely those same factors, as well as cognitive, biologic, and developmental influences exist for children and adolescents.

References


