SUICIDAL CHILDREN

©JOHN DUBÉ

B.S.W., University of Calgary, 1986

A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfilment of the
Requirements for the Degree

MASTER OF EDUCATION

FACULTY OF EDUCATION

LETHBRIDGE, ALBERTA

January 2005

Dedication

To children who have thought, attempted, and committed suicide as the means to end the pain they are experiencing.

Acknowledgements

The completion of my thesis is due in part to many individuals, some of whom are listed here. I am truly grateful for all their support.

Dr. Robert Runté, my supervisor and mentor, with whom I could speak my thoughts and feelings as I struggled and wrote.

Dr. Jean Collins, my first social work supervisor, who inspired me to work in the area of suicidology.

Cliff Thorbes, my friend, who listened and supported me throughout the years of research, reading and writing this study.

James MacKay, for all the conversations, reading, editing, feedback and patience he provided on my thesis journey.

Michael Kerr, for his ear, courage and quiet strength that have helped me complete this project.

And finally, Dr. Israel Orbach, Jennifer White, and Myra Morrant for their feedback and reflections concerning the list of literature analyzed in this research study.

Abstract

This study gathers the literature on suicidal children and creates guidelines designed to assist professionals with assessing the suicidality of a child. Analysis of the literature reveals that there are varying ages of children used in the research, a lack of standardization for the definition of suicide, and resistance towards a collective research approach to understanding suicidal behaviour. The literature also identifies the important risk factors, which are incorporated into guidelines for determining the suicidality of a child: family discord and violence, depression, significant loss, poor and/or dysfunctional parent/child communication and bonding, aggressive behaviour, stress, physical abuse, parental separation/divorce, hopelessness, academic difficulties, prior suicide attempts, and viewing death as a temporary state of being.

Table of Contents

Dedication iii

Acknowledgements iv

Abstract v

Table of Contents vi

List of Tables viii

Chapter 1. Introduction 1

The Reality of Childhood Suicides 1

Purpose of the Study 3

Chapter Two. Literature Review 5

Defining the Literature 5

Criteria for Selection of Appropriate Literature 5

Strategies for Locating Relevant Literature 9

Limitations on the Selection of Literature 13

Number of Articles in the Study 15

Defining Suicide 17

Development of Death Understanding in Children 24

Death Understanding and Suicide Risk Level 34

Professionals' Reluctance to Acknowledge Suicidal Children 35

Inconsistency in the Age Range of Suicidal Children 37

Risk Factors Associated with Suicidal Children 38

Family Discord and Violence 40

Depressive Symptoms 41

Significant Loss 42

Poor or Dysfunctional Parent-Child Communication and Bonding 43

Aggressive Behaviour 44

Stress 46

Physical Abuse 46

Parental Separation and/or Divorce 48

Hopelessness 50

Academic Difficulties 50

Prior Suicide Attempts 51

Gender 54

Summary 55

Chapter 3. Disseminating Findings from the Research Literature to the Suicide Prevention/Intervention Professional 57

Development of a Practitioner's Guideline Qualifying Childhood Suicidality 60

Context for the Guidelines Qualifying Childhood Suicidality 63

Chapter 4. Discussion and Further Areas for Study 67

Child Suicide Risk Assessments 69

Further Research 70

References 72

Appendix A. Literature Excluded From Analysis 83

Appendix B. Literature Included in Analysis 85

Appendix C. Qualifying Childhood Suicidality: A Professional's Guide 97

List of Tables

Table 1. Disciplines Represented in the Study 16

Table 2. Date of Publication 17

Table 3. Age Range of Children in the Literature 38

Table 4. Suicide Risk Factors for Children 39

Table 5. Qualifying Childhood Suicidality: A Practitioner's Guideline 62

Chapter 1. Introduction

The Reality of Childhood Suicides

> When I was five years of age, I remember vividly standing on a stool in my parents' basement, with a loaded gun resting on the floor and the barrel in my mouth, wanting to end it all, end the pain, end my worthless life. In time I realized that no matter how hard I tried to reach the trigger, my arms would never be long enough; I would never be good enough; even in trying to kill myself, I was a failure (personal communication, adult client, February, 2000).

It is hard to comprehend a five year-old attempting or committing suicide and ending a life that has just begun. Story after story of children attempting and completing suicide haunts me as I explore this topic.

Paulson, Stone and Sposto's (1978) work with children who attempted suicide provided compelling evidence of the reality of this phenomenon: a four-year-old boy was found hanging out of a fourth floor window; a six-year-old boy tried to cut himself with his father's razor and said, "I want to die"; another six-year-old was found hanging out of a second floor window saying "I want to die"; a seven year-old boy stabbed pins and needles into his stomach; an eight-year-old girl deliberately turned off the cold water while taking her bath and received second degree burns; a nine-year-old boy attempted to hang himself; and finally, a ten-year-old boy ingested tranquilizers and aspirin twice in four days.

Pfeffer (1984) conducted a study that indicated that approximately 12 percent of school children who had no previous history of mental health concerns harboured suicidal ideas or displayed suicidal acts. Another study conducted by Carlson, Asarnow, and

Orbach (1987) indicated that approximately 15 percent of normal school children between the ages of eight and thirteen admitted to suicidal ideas. As Stiles and Kottman (1990) stated, "About 200 suicides of children under the age of 12 are reported annually in the United States . . . [and] twenty-five thousand children are hospitalized . . . because they express suicidal thoughts" (p. 337). Suicidal children are real.

Statistics Canada (2002) reported that, in 1997, there were 3,681 reported suicide deaths in Canada. Reported suicides are identified through the cause of death noted by medical coroners on death certificates. Of the 3,681, 79 percent (2,914) were men, and the remaining 21 percent were women. By age range, 51 persons who committed suicide were between 1 and 14; 261 were between 15 and 19; 293 were between 20 and 24; 1,549 were between 25 and 44; 1,060 were between 45 and 64; and the remaining 452 were over 65 years of age. Therefore, within the context of all suicides in Canada, only 1.4 percent of suicides were individuals under the age of 14.

However, suicidal deaths are notoriously underreported (Appleby 1994; McGuire & Ely, 1984; Mishara, 1999). The reporting of epidemiological data on suicide rates and actual occurrences varies widely from county to county, region to region, province to province, and country to country. Determination of the cause of death lies in the domain of coroners and doctors. How coroners and doctors choose to define the death of a child is influenced by deeply ingrained cultural values relating to the social, cultural, religious and political attitudes of the country and themselves as individuals (Freedman, 1975). As a result, the beliefs, moral values and judgement of coroners and doctors greatly influence how they interpret the cause of death.

To compound matters, Ginn, Range and Hailey's (1988) research on community attitudes towards suicide was most revealing. They discovered that families of children who commit suicide receive less emotional support from the community than they would after any other loss by death. Stigma plays a major role in the shame that the survivors experience; it can and does significantly hinder the healing process following the loss of a child. Regardless, the lack of acceptance that children want to, can, and do kill themselves is still pervasive, even in the professional world (Banister, 1995; Charles& Matheson, 1988; Dugan & Belfer, 1989; Ginn, Range & Hailey, 1988; Greene, 1994; Mishara, 1999). This lack of support for the surviving bereaved family can only reinforce the practice of underreporting suicides of children.

Purpose of the Study

Although much has been written on the topic of suicide, little focuses on suicidal children. Therefore, this study attempts to gather together as much literature as possible with a focus on suicidal children. The gathered literature provides evidence that suicidal children do exist, and that those in many disciplinary fields, such as psychiatry, psychology, sociology, education, and social work, have concerns about this population group. Gathering the literature together provides an overview of what professionals are noting and what their concerns are, and identifies risk factors that are unique to suicidal children.

Although the French psychiatrist M. Durand-Fardel wrote the first article on suicidal children in 1855 (cited in Baartman, 1994), the ratio between articles on suicidal adolescents and articles on suicidal children is approximately a thousand to one. Varying ages of children are used in research studies. Furthermore, there is no standardized

definition of suicide and its derivatives. Researchers seem to resist becoming more collaborative in their work and approach to suicidal behaviour. Together, these factors render a review of the literature on child suicide difficult (Goldsmith, Pellmar, Kleinman, & Bunney, 2002; Goldston, 2000; O'Carroll, Berman, Maris, Moscicki, Tanney & Silverman, 1996). In spite of these challenges and inconsistencies, it remains important to review the current research in order to consolidate the existing literature in the area of suicidal children. I have attempted to create a document that will assist suicidologists and other professionals charged with the safety and well being of children in more effectively recognizing and addressing the issue of child suicide.

Therefore, this study had two purposes: to gather professional literature from a wide selection of disciplines for an analysis of the topic of suicidal children, and to create for professionals working with suicidal children a set of literature-based guidelines that would inform their individual intervention paradigms. The analysis of the literature explores areas of consensus and disagreement, identifies trends that emerge, reviews the important risk factors in identifying the suicidality of children, and finally makes recommendations for further study. The guidelines are designed to inform professionals of the risk factors that are identified in the literature as crucial for understanding suicidal children and their families.

Chapter Two. Literature Review

An extensive literature review is the cornerstone of this study. It was conducted within the context of my 18 years of experience in the area of suicide prevention, intervention and post-intervention work. The search for relevant literature began in the fall of 1999 and continued through July 2003.

Defining the Literature

Criteria for Selection of Appropriate Literature

The literature search commenced in the area of suicidology, but it did not remain within that narrow discipline. It was important to gather literature from a broad set of disciplines. The issues and concerns related to suicidal children are not focused in one particular area, such as suicidology. They are of concern in a wide spectrum of professional disciplines, such as education, psychology, psychiatry, social work, nursing, or any other discipline where a child's well being is considered part of the field.

Before I began seeking out literature on suicidal children, I set out parameters for selection of appropriate literature to be included in the content analysis of the study. Having an established set of criteria helped me to maintain a focus and kept the gathering process manageable. The following criteria determined the inclusion or exclusion of literature for the study.

Articles were selected whose title contained the words "suicide" and "child" together, or any variations of these two words, such as "prepubescent," "middle childhood," "preadolescent," "latency aged child," "self harm," "suicide attempts," or "parasuicide." Authors use titles to capture the essence of the topic discussed in their articles. Therefore, use of the title as the key screening point ensured linkage between

child and suicide. I wanted to obtain articles that had a primary focus on the issues related to and concerns of suicidal children. As a result, appropriate articles appeared during application of the search strategies.

To ensure the scholarly integrity of the current review, only studies published in peer reviewed or scholarly journals, book chapters and books were included. Newsletters, editorials, grant reports, conference proceedings, and other unpublished documents were excluded from the review.

All articles were topically focused on suicidal children; therefore, articles that focused on adolescents or adults were excluded from the study. If an article's title included the word "child" or "children" and "suicide," and yet review of the body of the article showed that it contained no information on suicidal children, the article was excluded. Four articles fell into this category. In "Suicide Prevention and Intervention in Child Care Programs," Charles and Matheson (1988) use the terms "young people," "children," and "adolescents" interchangeably, thus providing no clarity as to which issues or concerns were attributed to children and which to adolescents. In "Examining Claims about Gifted Children and Suicide," Cross (1996) focused on children aged 15 to 24, outside the age parameters set for this study of 5 to 12 years of age. In "Annotation: Mood Disorder in Suicidal Children and Adolescents: Recent Developments," Flisher (1999) reviewed research studies conducted on individuals with an age range from 9 to 18, but failed to distinguish between children and adolescents when presenting the results. Rao, Weissman, Martin, and Hammond (1993) wrote "Childhood Depression and Risk of Suicide: A Preliminary Report of a Longitudinal Study." The authors used an age definition so vague as to be useless, since it defined age as "associated with mortality by

suicide in late adolescence or early adulthood" (p. 26). Although these four articles had originally met all the literature selection criteria, they did not contain any information on suicidal children, and therefore they were excluded.

When an article contained information on both children and adolescents, I carefully extracted point by point the data on children only and excluded any information on adolescents or other age groups. Of the articles selected for review, 11 articles fell into this category. For example, in "Clinical Interviews with Children and Adolescents," Barker (1990) discussed the development of death understanding in children, from early childhood to older childhood and into adolescence. Barker clearly demarcated the definition of the development of death understanding in such as way as to help the reader to distinguish which attributes are assigned to a child versus an adolescent. "Suicide in Children, Adolescents and Seniors: Key Findings and Policy Implications" (Dyck, Mishara, & White, 1998) is written in distinct and definable paragraphs. As a result, when the authors introduce an issue, it is discussed uniquely in one paragraph focused on children, another paragraph focused on adolescents, another on the adult population, and a final paragraph concerning the same issue in the senior population. The authors clearly attempt to distinguish each population group, not only to identify the unique risk factors for each population group but also to demonstrate the similarities and differences between the population groups.

When several articles were written based on the same research findings, the duplicate articles were excluded. For example, Pfeffer's "Modalities of Treatment for Suicidal Children: An Overview of the Literature on Current Practice" was published in the *American Journal of Psychotherapy* in 1984 and published again as a chapter in *What*

We Know About Suicidal Behaviour and How to Treat It (1988). Since the articles are identical, only one was needed for the content analysis of the literature. I included the earliest article in order to keep the original publishing date consistent with the time period of the research and the information collected.

On one occasion, it was discovered that a single yet complex research study had been conducted which resulted in several published articles by the same authors. I carefully reviewed all the articles and determined that each article contained different and unique information, although the articles were based on the same data set. As a result, each article was included in order to enrich the data set of this study. The research in question was conducted by Pfeffer, Hurt, Kakuma, Perskin, Siefker, and Nagabhairava in the mid-to-late 1980s; it included six to eight years of follow-up research on children who had attempted suicide. As a result, four key articles were written and published at different times in the *Journal of American Academy of Child and Adolescent Psychiatry*: "Suicidal Children Grow Up: Rates and Psychological Risk Factors for Suicide Attempts During Follow-Up" (1993); "Suicidal Children Grow Up: Suicidal Episodes and Effects of Treatment During Follow-Up" (1994); "Suicidal Children Grow Up: Suicidal Behaviour and Psychiatric Disorders Among Relatives" (1994); and "Suicidal Children Grow Up: Ego Functions Associated with Suicide Attempts" (1995).

Two authors in particular, C. R. Pfeffer and I. Orbach, have written prolifically on the topic of suicidal children. It was important for this study to review their work carefully and to include their findings, while not biasing the whole data set because of the extensive writing by these two authors. It was critical to report on trends, issues, concerns and controversies noted in the literature, based on work by all the authors who have

written on suicidal children, and not to overemphasize any one author but to ensure all authors equal weight throughout the data analysis process. The method used to accomplish this goal involved tracking each article; extracting its information, for example the suicide risk factors noted in the article; and entering the information in a data table. Then the data table was reviewed to ensure that articles written by the same author, such as Pfeffer and Orbach, were not over represented so as to skew the data. For example, if ten articles written by Pfeffer each noted that family violence was a suicide risk factor, this risk factor was noted once in the table data, not ten times.

Strategies for Locating Relevant Literature

Having established criteria assisted me with searching out and keeping a clear focus on selecting the appropriate literature for analysis. However, I was still daunted by the task of finding as many articles as possible that focused on suicidal children. I used a step-by-step process to maintain focus and boundaries as I gathered the necessary literature.

I utilized the database PsycINFO, which reviews over 1,890 journals covering such areas as medicine, management, addictions, psychology, sociology, teaching and social work. PsycINFO contains articles published from 1887 to the present.

ERIC and ERIC Digest are two databases specific to the field of education. While ERIC reviews education-based journal articles from 1966 to present, ERIC Digest provides short reports on primary topics and trends in education and references these reports from 1982 to the present.

The Academic Search Premier is a multi-disciplinary database that provides abstracts from approximately 7,780 journals and full-text articles from approximately

3,900 journals across nearly all academic disciplines. This database can search articles from 1965 to the present.

Sociological Abstracts provided access to the world's literature in sociology and related disciplines, such as social work. Sociological Abstracts covers articles published from 1963 to the present.

Accessing various databases provided coverage of journals in which scholarly work on the topic under investigation was likely to appear. Although some databases searched similar journals, this overlap was useful in reducing gaps in the search pattern. For example, PsycINFO and Academic Search Premier both accessed certain journals related to education and social work.

Within each database I used the phrases "suicidal children," "children suicidal," "suicide child," "suicidal preadolescent," "suicidal prepubescent," "suicidal latency age child," "depression and children," "depressed children," and "mental health child" in developing a search pattern. These search terms were used not only in the title field but also in the subject field.

When an article met the criteria for inclusion, I carefully reviewed its reference list for additional literature. Investigation of the literature reviews and searches already conducted by other researchers and writers resulted in an expansion of the range and scope of search for appropriate literature. A careful review of the published articles' reference lists provided another source of potential articles that were reviewed, assessed, and either determined to be part of the analysis or excluded.

A particular article came to light through this process. John McIntosh's doctoral dissertation was published in 1996 in the *Suicide and Life-Threatening Behaviour*

Journal. The article identified all the doctoral dissertations on various aspects of suicide that had been published in the United States and Canada from 1990 to 1995. An abstract was included for each dissertation discussed in the article. I then expanded my search of master's and doctoral dissertations by utilizing the database Proquest Digital Dissertations. I discovered three doctoral theses with a focus on suicidal children: Michalik-Bonner's (1990) *An Investigation of the Relationship Between Behaviour Style, Perceptions of Family Environment and Suicidal Ideation in Children*, Indiana University of Pennsylvania; Clark's (1994) *Exploring the Concept of Suicide in Children Through Stories: A Case Study Approach*, Florida State University; and Kestenbaum's (1992) *Suicidal Versus Non-Suicidal Children: Psychological, Cognitive, Psychiatric and Family History Differences*, California School of Professional Psychology. These three doctoral theses provided strong reference listings for review.

World Wide Web search engines, such as Metacrawler, Google, and Alltheweb, were utilized to find databases that focused on suicide literature. Through this search I discovered suicide-specific websites such as those of the Canadian Association for Suicide Prevention, the American Association of Suicidology, the Australian Institute for Suicide Research, The Samaritans-Befrienders International, and National Youth Suicide Prevention. At each of these websites, I searched for information on suicidal children. Furthermore, through these search engines I gained access to journal-specific websites, such as *The Journal of American Academy of Child and Adolescent Psychiatry* and *The Journal of American Academy of Child and Adolescent Psychiatry and Pediatrics*, as well as more general websites, such as those of the United States Surgeon General,

United States National Vital Statistics, Statistics Canada, and the National Academy of Sciences.

Another key source of literature for the study came from the Suicide Information and Education Centre (SIEC), a special library and resource center that provides research-focused information and training resources on suicide and suicidal behaviour. Its mandate is to collect all the English language documents that can be found on suicide and suicidal behaviour. Therefore, SIEC contains the world's most extensive publicly accessible concentration of articles in the area of suicidology.

I first accessed SIEC's literature through a visit to the Centre's office in Calgary, Alberta, Canada. Later, I registered with the Centre to access their encrypted online database and conducted searches for articles appropriate for my study. Then I enlisted the help of the SIEC librarian to obtain physical copies of the articles, which were forwarded to me for review. When approximately 50 articles had been gathered and accepted for the study, I noted that several authors' articles and concepts were showing up repeatedly in various reference listings. Pfeffer, Orbach and O'Carroll were most likely to be cited by other authors.

The final strategy I used to ensure that the reference listing was as complete as possible was to forward the selected reference list to three experts in the field of suicidology. Jennifer White, M.A., former Provincial Youth Suicidologist of Alberta (1991-1994) and most recently the former British Columbia Provincial Suicidologist (1994-2002), is with the Department of Psychiatry, University of British Columbia. Dr. Israel Orbach, Bar-Ilan University in Israel, was for a number of years a senior clinical psychologist at the Adolescent Suicide Clinic of Albert Einstein School of Medicine in

New York. He has written and co-authored over 50 published articles in the area of suicide and is one of two authors to have written a book exclusively focused on suicidal children. Myra Morrant, the main librarian for the Suicide Information and Education Centre, has researched, gathered and catalogued suicide related literature for 13 years.

Limitations on the Selection of Literature

In order to impose a time limit for gathering appropriate literature for analysis, only articles published between January 1970 and June 2003 were selected for the study. Approximately 34 percent of the literature on suicidal children was published between 1990 and 1994, while less than 10 percent of the literature was published between 1970 and 1979. It appears that interest in the area of suicidal children increased in the early 1990s. Prior to this time, little was written about this phenomenon. I did not analyze literature published prior to 1970, since articles published before that date were not cited. Additionally, such early publications might be assumed to have little relevance today, since the field of suicidology emerged and solidified in the 1990s. Therefore, using the time span of 1970 to 2003 provided a generous buffer to ensure capture of the most relevant and current information on suicidal children.

I gathered only articles written in English and thus did not need to translate any information, hence ensuring some level of comparative consistency between articles. The articles selected were derived primarily from Western industrialized countries, such as England, Australia, the United States, and Canada.

A review of the current suicide literature is fraught with difficulties, as O'Carroll, Berman, Maris, Moscicki, Tanney, and Silverman (1996) illustrate:

> A medical sociologist wishes to conduct research to refine and clarify the relative efficacy of several common treatment approaches to suicide attempters. Unfortunately, in her review of the literature she finds that, although numerous studies have been done in this area, none are directly comparable. She determines that the equivocal nature of the combined results of theses studies is due largely to the following: (1) some researchers included all cases of overdose in their studies of "suicide attempters," regardless of intent, whereas others did not; (2) some did not distinguish suicidal ideation from suicidal acts; (3) some indiscriminately mixed first and third person reports of attempts in identifying study subjects; (4) others did not control for various methods of attempting; and (5) few used any operational definition of "lethality" (or other method for discriminating "serious" from "non–serious" attempts) – and those that did, used methods unique to their studies. Frustrated, she is forced to design a study based on a case definition of her own choosing – a study that, although well conceived, will yield results that are, in turn, not directly comparable to previous research efforts. (pp. 237–238)

This example can be applied not only to the lack of consistency in the age range used in research about children, but to the lack of consistency in understanding suicide and suicidal behaviours and in research strategies. The cited example demonstrates that researchers must begin to consider the work of other researchers and develop research strategies that take into consideration current and future research studies. A broader perspective must be engaged in order to develop the field and discipline of suicidology. Researchers need to develop their research strategies in such a way as to strengthen the comparability of research projects and researchers. They need to look at the needs of the

field of suicidology as a whole, not just their own needs. It is vital that researchers approach the topic of suicide collectively and consistently.

Number of Articles in the Study

The review of selected appropriate literature began with articles and books whose titles contained both the words "suicide" (and its derivatives) and "child" (and its derivatives). This search strategy produced 111 articles and 7 books. Each article and book was then carefully read and reviewed for content. Because their content focused on suicidal adolescents and not on suicidal children, 12 articles and no books were excluded from the analysis (see Appendix A). In the end, 106 articles and books were used in the analysis. It must be noted that 11 articles contained information on both children and adolescents. Only information pertaining to children was included in the analysis. Appendix B lists the literature selected for analysis in this study.

For the study to be comprehensive, it was important to obtain literature from a broad range of disciplines. Table 2 categorizes the selected articles into various disciplines. It reveals that the phenomenon of suicidal children is not isolated to any one particular field, and that concern for children who want to kill themselves cuts across multiple professional disciplines.

Table 1. Disciplines Represented in the Study

Discipline	Percentage of articles included in study
Psychiatry	22.5%
Psychology	22.4%
Suicidology	14.6%
Education	13.5%
Thanatology	12.4%
Medicine	11.2%
Social Work	3.4%

A careful review of the general content of the articles across the years of publication revealed no significant differences. Articles provided information concerning the statistical phenomenon of suicidal children, the risk factors associated with suicidal children, family and environment influences on children, and various therapeutic interventions for working with suicidal children.

The selected literature can also be divided into three broad categories: 51.4 percent of articles reported a research study; 11.4 percent were case studies; the remaining 37.2 percent provided information and training concerning the phenomenon of suicidal children, noting the risk factors associated with suicidal children and exploring successful intervention strategies.

The selected articles were published between 1970 and June 2003. This span of time provided a useful time-frame boundary. It represents the years when most articles on

suicidal children were published. Approximately 60 percent of the articles were written within the ten-year period from 1985 to 1994.

Table 2. Date of Publication

Date Range	Percentage of articles included in study
1970 to 1980	9.0%
1980 to 1984	18.3%
1985 to 1989	24.7%
1990 to 1994	33.7%
1995 to 1999	9.8%
2000 to June 2003	4.5%

Defining Suicide

If a social worker, psychiatrist, elementary school teacher, or bereaved individual were asked to define "suicide," each would probably express different definitions and understandings of the term. This would occur, in part, because of these individuals' unique life experiences, educational backgrounds, and personal life philosophies. The social worker might define suicide in relation to social justice issues, such as socio-economic factors, the marginalization of people, and poverty. A psychiatrist might define suicide in relation to brain functioning, chemical imbalances and mental illness diagnoses using the Diagnostic Statistical Manual of Mental Disorders IV Edition. An elementary school teacher might not consider suicide an important factor in his or her teaching environment with children and might not have the knowledge even to begin defining suicide in an academic sense. A bereaved individual might define suicide in terms of the pain he or she has experienced because of the choice and action of another person. In all

cases, these individuals' definitions would be correct given their personal experience. Each of their perspectives defines some aspect of suicide.

Researchers and suicidologists do not have the luxury of utilizing individual, discipline-specific definitions of suicide. Having different definitions undermines the consistency in the approach to, understanding of, research into, and treatment of suicidal individuals. Let us take the example of a patient admitted into hospital after a suicide attempt. During the case conference concerning the patient, the definition of what constitutes a suicide attempt may not be discussed. Typically discussed are the intervention strategies each member of the intervention team would undertake in treating the patient. However, the lack of definition and understanding of suicide may cause confusion, and as a result, the professional team members may approach and treat the patient at cross-purposes. The psychiatrist focuses on what medications would be appropriate to alleviate the immediate psychiatric symptoms, while the social worker tries to gain an understanding of the patient's environment. The focus of one professional is on the biology of suicide, and another's is on the environmental context of suicide; this difference may result in very different intervention approaches. While their approaches may or may not work, the situation clearly indicates that an understanding of suicide is highly dependent on professional and personal perspective. The team may not necessarily be working at odds with each other; however, each member is focusing on a different aspect of the whole person, the mental, physical, emotional or spiritual components. The lack of clarity surrounding the term "suicide" can result in a less cohesive plan of intervention.

Suicide has many faces: an act of crime, a rational and honourable act, evidence of insanity, a sin, or a failure to cope (Stillion & McDowell, 1996, p. 38). Suicide is judged and defined differently by different cultures at different times. However, as Shneidman (1973) stated, "Every case of overt self-destruction involves the pressure of phenomenological felt unbearable anguish, and in this sense, suicide is better understood as an escape from rather than a going toward" (quoted in Freedman, 1975, p. 1774). However, it can be argued that not all suicides are committed in "anguish." Japanese Kamikaze pilots during World War II, Iraqi suicide bombers, or Chinese Falun Gong believers may not be considered individuals who are in emotional pain, but rather individuals who are attempting to make a political statement.

The lack of consistency in the definition of suicide is evident throughout the research literature. Of the articles reviewed, 67.1 percent made no attempt to provide a definition of suicide or suicide in relation to children, while 32.9 percent did include some type of definition. O'Carroll et al. (1996) discussed the importance of developing a nomenclature for suicide; however, these authors did not discuss their standardization of suicide definitions in relation to children. It is interesting to note that the definition of suicide and its derivatives did become more consistent after the O'Carroll et al. (1966) article. Pfeffer (1997), Goldston (2000), and Ashworth (2001) note the O'Carroll et al. (1996) nomenclature as the basis of definition for their work. Furthermore, articles written since 1996 about suicidal children have focused more on definitions and the need to develop a nomenclature concerning the various suicidal behaviours.

"The word *suicide* translates literally from its Latin origin, a combination of *sui*, 'of oneself,' and *cide*, 'a killing,' to become in English 'to kill oneself' (Evans &

Farberow, 1988). Although this appears to be a clear-cut definition, suicidologists, researchers, and medical and social scientists still cannot agree on an operational definition of intentional self-destructive behaviour. Suicidal ideation, intentions, gestures, attempts and completions may be interpreted differently depending on a researcher's theoretical orientation, area of expertise, specific line of work, or research parameters. During the review of literature, various definitions for suicide were gathered to determine whether a common understanding of the term "suicide" was being used. It is important to develop a common understanding of this complex range of behaviour for various reasons: 1) to provide context and clarity on assessing the risk levels of suicidal individuals; 2) to assist the Medical Examiner in determining cause of death; 3) to provide clarity to the professional working with families bereaved by suicide; 4) to provide context for families working through the bereavement process; and 5) to provide context, clarity and consistency for researchers conducting studies in the area of suicide. Defining the word "suicide" is difficult, but not impossible, since approximately 30 percent of the literature reviewed for this study provides a definition or points of reference for the term.

Goldsmith, Pellmar, Kleinman, and Bunney (2002) note that the discussion of a standardized nomenclature of operational definitions for basic terms such as "suicidal ideation," "suicide attempts," and "completed suicide" has continued for over 30 years without resolution (p. 376). O'Carroll et al. (1996) drafted a standardized nomenclature of suicidal behaviours based on workshops held in the mid 1990s by the American Association of Suicidology, the National Institute of Mental Health, and the Center for Mental Health Services researchers. However, some writers still resist using O'Carroll and colleagues' nomenclature as a baseline. Research by Klimes-Dougan, Free,

Ronsaville, Stilwell, Welsh and Radke-Yarrow (1999), which used a four-type tier nomenclature, demonstrated this resistance. However, other authors such as Ashwood (2001) and Goldston (2000) use the O'Carroll et al. (1996) nomenclature.

To this point, the definition of suicide has been discussed in broad terms. To fully appreciate the complexity of suicide and to provide a foundation for understanding suicide, a closer examination of historical and current researchers who contributed to the understanding of suicide is required.

Durkheim, the grandfather of suicidology (Simpson, 1979), provides the cornerstone for all definitions of the word "suicide." Durkheim defined the term as applying "to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result. An attempt is an act thus defined but falling short of actual death" (quoted in Simpson, 1979, p. 44). Durkheim divided suicide behaviour into four categories: egoistic suicide, altruistic suicide, anomic suicide, and fatalistic suicide. "Egoistic suicide" applies when a person feels alienated from society and has few, if any, binding ties to such groups as family, church, business, or education, and few social or recreational bonds. "Altruistic suicide" applies to those individuals who are totally absorbed by a social cause that calls on their support up to and including the loss of their lives, for example, terrorist bombers. "Anomic suicide" occurs when an individual is confused and experiences a sense of loss, for example, when traditional values and mores have undergone a marked and significant change that is so profound that the individual's life has lost meaning. Finally, "fatalistic suicide" applies to individuals who have experienced such excessive constraints and

repression that to die is to gain freedom. Many fatalistic suicides occurred in Warsaw's Jewish ghetto and in holocaust camps.

Shneidman (1994) showed that effective suicide intervention depends on accurate assessment, which in turn depends on meaningful definition. Defining the word "suicide" and its sub-categories, Shneidman stated that, "Suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution" (p. 203). He went on to clarify that the term "suicide" is often (perhaps typically) used with two meanings: "the definition of the *act* of self-destruction, and some delineation of the *person* who commits the act" (p. 204). In other words, it is not sufficient to describe suicide solely as an act; it is also important to include the individual committing the act in order to define suicide more completely.

Pfeffer (1986), a highly respected suicidologist in the area of children and suicidal behaviours, suggested the following:

> A modification in the [Shneidman] definition should incorporate the idea that it is not necessary for a child to have an understanding of the finality of death, but it is necessary to have a concept of death, regardless of how idiosyncratic it may be. Therefore, suicidal behaviour in children can be defined as any self-destructive behaviour that has intent to seriously damage oneself or cause death. (p. 14).

Orbach (1988), another highly respected suicidologist, defined suicide through a model using four basic attitudes to life and death typically held by children: attraction to life, repulsion to life, attraction to death, repulsion to death. The premise was that suicidal behaviour is an end result of these four opposing forces, which operate simultaneously

and which a child knowingly or unknowingly engages in balancing. For Orbach, suicide is an act of free will within the specific constraints governing this choice. This choice is not founded on a moral imperative, but is the product of intense and unbearable suffering.

Evans and Farberow (1988) chose not to define suicide but quoted McIntosh, who suggested that, "No single term, definition or taxonomy yet serves sufficiently to represent . . . the complex set of behaviours that have been suggested as suicidal" (p. 84).

In 1994, the National Institute of Mental Health and the Centre for Mental Health Services of the Substance Abuse and Mental Health Services Administration held a workshop titled "Dimensions and Classifications of Suicide Morbidity: Drafted Standardized Nomenclature of Suicidal Behaviours." The results of the workshop were published by O'Carroll et al. in 1996. Suicide and its complex components were defined as "death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted and that the decedent intended to kill himself/herself" (pp. 246-247). Based on this definition of suicide, the article further defined "suicide attempt with injuries," "suicide attempt," "suicidal act," "instrumental suicide-related behaviour," "suicide-related behaviour," "suicide threat," and "suicidal ideation."

The following section discusses the debate concerning and complexities related to defining suicide in children. The debate rests on the fact that definitions of suicide include a key element, that an individual knows that the act being contemplated will end his or her life. At what age and in what circumstances do children gain the self–awareness to know that death, and in particular their own death, is permanent and can be caused by their own deliberate behaviour?

Israel Orbach (1988) commented that, "Searching for theoretical hairs to split leads to unintentional neglect of the person, his world of experiences, and his attitude toward life and death, which may result in a suicide" (p. 12).

Development of Death Understanding in Children

One of the cornerstones in defining suicide is the need for the suicidal individual to be aware and to intend consciously to cause his or her own death. This need for awareness and the intention to carry through with a behaviour that will permanently end the individual's life raises questions. Can children commit suicide? When do children develop the cognitive understanding that death is permanent not only for others but for themselves? If a child does not have the cognitive understanding of the permanency of his or her death, is the child incapable of committing suicide? If one defines suicide as the conscious and deliberate act of taking one's life, it could be concluded that children, who do not have a conceptual understanding of the permanency of their own death until after the age of nine (Stefanowski-Harding, 1990), cannot commit suicide.

Some psychoanalysts have asserted unequivocally that children under the age of twelve are incapable of suicide because they have not developed the understanding that the permanency of death applies to them as well as to those around them. According to Orbach (1988), the arguments are varied and impressive: "Children are incapable of the guilt or destructive terror needed for suicide"; "Children don't understand the concept of death"; "Children couldn't carry it out even if they wanted to, since they can't deal with the complexities of planning" (p. 13). Others suggest modifications in the definition of suicide in relation to children, for example, that suicide in children is any self-destructive

behaviour that has intent to seriously damage oneself or to cause death (Pfeffer, 1985; Sokol & Pfeffer, 1992).

To begin addressing this aspect of the debate, we must examine the complexity of cognitive development in humans. Winzer (1994) discusses Piaget's theory on child psychosocial development in depth and is the basis of the following summation. Piaget speculated, through observations of his own children, that people mature and change their process of thought through discrete and non-continuous stages. Piaget's theory of stages of development was broadly tied to age spans but not chronologically specific. The stages of development are sensorimotor, preoperational, concrete operational, and formal operational.

The sensorimotor stage (birth to age two) focuses on the development of motor and perceptual capacity in encounters with the world. At this point, the child has no general concept of object permanence, or the notion that the existence or non-existence of objects does not depend on one's immediate perception of them. For example, when a mother leaves the room, the child becomes frightened that she is now permanently gone.

The preoperational stage (ages two to seven) begins with the initial acquisition of language and symbolic thought, thus allowing for broader comprehension of self and the world. In the first part of this stage (ages two to four), thoughts are characterized by egocentric animism and magic. The child sees himself or herself as the center of the world: everything is centered on the wants and wishes of the child. Thoughts and words are powerful and can take on magical properties.

During the second part of this stage (ages four to seven), there is an accelerated acquisition of language and enhanced use of symbolism and abstract thought. However,

cognitive functioning is still based on what Piaget terms "pre-logical thinking." The child is still bound to the concrete world, to things that can be perceived by the senses. The pattern of learning and solving problems is basically through trial and error. In this second part, there is a drop in egocentric thought and behaviour, with a growing interest in what causes things to happen. This stage of development is saturated with "why" questions. However, the child's perception of time remains a matter of subjective experience, not yet perceived in a continuous flow toward the future. Finally, the first real signs of self-definition and movements toward independence and peer individuals appear at this stage.

How do children in the preoperational stage understand death? Between the ages of three and five, children focus primarily on the physical aspects of death. For example, children may poke sticks into a dead animal. They also show great interest in the immediate conditions of death, such as a person's coldness, position, and skin color. They may begin to associate death with abandonment and neglect. At this stage, children have difficulty distinguishing between death as a state and death as a natural process (Orbach, 1988). As a result, they have a partial understanding of death and its causes, accompanied by a distortion in perception. Children at this stage relate to death in a concrete and situational manner, overlaid with magical thinking and generalization. They may see death as a temporary and reversible condition. Fitzgerald (1992) and Kubler-Ross (1983) both suggest that parents be honest and answer questions factually, using language that is appropriate and understandable to the child, when discussing a child's concerns or questions about death.

In the concrete operational stage (ages seven to twelve), children begin to apply logic to problem solving. Children in this stage are capable of categorizing objects on the basis of differences and similarities and are able to make deductions or inductions. They can now think sequentially, with one logical step following another. They can go back over a problem and break it down into its components. They depend less on the senses and rely more on logic and imagination. However, as much as children advance in their thinking processes, concrete operational children still have difficulty grasping the relationship of cause and effect. Although they are capable of representing the world in symbols, they still falter in expressing the possible connections between these symbols.

In the concrete operational stage, children experience an explosion of growth. They take the initial steps toward comprehending concepts such as time, space, conservation, cause and effect. An extended sense of self and a growing feeling of autonomy parallel these cognitive advances. As a result, children at this stage give concrete reasons for causes of death: cancer, heart attack, old age and disease. Although all these answers are correct, they remain linked to the concrete world and do not reflect an ability to abstract the underlying biological or spiritual processes. Children between ages seven and eight can display an interest in, and fear of, the supernatural, ghosts, gods, witches, and the forces of nature. They begin to show an intense interest in death, are anxious about family members' well being, fear possible abandonment, and begin to understand the process of aging. They now experience time as a continuous process, which brings a clearer understanding of the meaning of death.

As children mature to nine to twelve years of age, their perceptions of death continue to alter. They demonstrate a continued interest in the supernatural and fear of

the death of loved ones, attribute death to age, disease and other internal forces, and begin to develop the ability to perceive the possibility of their own death.

In summary, Piaget's stages indicate that children do not begin to formulate the understanding of death until the preoperational stage (ages three to five). At this stage children are primarily aware of the physical aspects of death. As a result, they only partly understand death, its broader implications, and the possibility of their own death. As children move into the beginnings of the concrete operational stage, they develop even further understanding of the physical aspects of death. They are now able to provide concrete reasons as to the causes of death, but unable to comprehend the underlying abstract, biological or spiritual processes of death. By the end of this stage, children are developing their understanding to a more complete concept of death, including the ability to reflect upon their own death. Full mature, abstract and logical understanding of death does not occur until the child is at the abstract operational stage, which occurs at the age of twelve and older.

While Piaget focused on the children's cognitive development, others, in particular psychologists, focus on children's emotional development as they learn to conceptualize death (Kastenbaum, 1992; Kubler-Ross, 1983; Orbach, 1988; Pfeffer, 1990). A child's emotional responses as he or she develops clearer meanings of death vary with age. A young child, who has no language with which to communicate, is not prevented from experiencing and expressing feelings. Parents and other individuals communicate with the child from the moment of birth. Because the young child's being is so tied to feelings, the child is sensitive to the feelings of those who surround him or her. If a change occurs in the emotional atmosphere, the child senses it. When the loss is of a

person who is warm, giving and loving, the child realizes it. His or her nurtured world and sense of security are threatened in powerful ways. When a mother leaves a baby alone in a room, feelings are invoked in the child: fear of abandonment, isolation, vulnerability and anxiety. Separation can arouse in a child a sense of "not being," resulting in a move towards a generalized fear of death.

"Ring-Around-the Rosie," a popular children's game during the years of the Black Death, was an all-too-accurate representation of what was taking place around them. "Peek-a-Boo" is derived from an Old English phrase meaning "alive or dead?" (Kastenbaum, 1992) and is often played with very young children. Hide-and-seek is another example, in which the "it" is a dead person who pursues other children in order to bestow a fatal tag. Many a modern computer/video game focuses on death, either of "the enemy" or of the self, and these far outnumber any other type of popular games. Children are, and probably always have been, fascinated by death; they attempt both to control their anxieties and to improve their grasp of this mystery by incorporating death into their everyday thoughts, games, and rituals (Kastenbaum, 1992). It appears then that, during the ages of five through eight, the child is dealing with the emotional aspects surrounding the concept of death. At nine to twelve, the child has succeeded in creating defense mechanisms that preserve an internal balance between knowledge of and fear of death.

In addition to the cognitive and emotional aspects of the development of death understanding, a third aspect requires examination. This aspect relates to environmental factors, such as the death of a pet or of an immediate family member, or the child's experience of a terminal illness.

Nagy's (1959) research indicates that experiences of death, whether of an animal or a loved one, can help children aged four to six to understand the concept of death. It appears that, for children older than six, the death of someone or something close does not have a major impact on understanding of death. The younger child will display an understanding beyond that which cognitive development might have predicted at a certain age (Kastenbraum, 1992). Children's reactions to death experiences are clear and distinct. Some search for the missing person or animal, while others ask questions about a dead animal's lack of movement. Some express great anger over the loss of a cherished pet, worry about what happens after death, and express concerns about parents, siblings or close relatives. In most cases, the child is distressed and attempts to regain a new internal balance between the knowledge, experience, and fear of death -- far sooner than the child's peers who have not experienced a death in their immediate environment.

Directly connected with the child's experience of death is the caregiver's response to the child and to the death itself. Some adults feel a need to soften the event for the child, while others attempt to help the child face the true dimensions of the reality. The parent or close relative who explains the death must use simple words taken from the child's frame of reference. This will validate the child's experience and encourage the healing process. The straightforward but simple explanation in no way lessens the pain or shock of loss, but it does help the child to adjust.

In contrast, when an adult is not straightforward, or conducts drawn-out lectures, the child may experience confusion, frustration and a slowing of the healing process. The child must be allowed to determine the pace of the explanation. Answers must be simple, concrete, to the point, and framed at the child's level of understanding. Mystical

explanations are often frightening and confusing for children. Children may incorporate the confusing information into realistic and concrete conceptualization. Children are concrete observers and will not grasp abstract ideas about God or angels taking their "mummy" into the "sky" to live in "heaven." Children may begin to ask, "What cloud does God live on?" or "Does mommy have wings?" Those with strong religious beliefs may find it difficult to talk about death with their children.

In talking with a child about death, parents must be creative, simple and concrete and always frame the information at the child's level of understanding. The best explanations seem to be simple, direct, and drawn as much as possible from the child's own experiences. The relative concreteness of the younger child produces the least possible distortion. Those who undertake to talk about death to a child would be wise to ask the child to explain back what he or she has been told. This will allow the opportunity to correct any gross distortions (Koocher, 1973).

An interesting pattern emerged in the literature concerning the development of death understanding in children. Many researchers (Carlson, Asarnow & Orbach, 1987; Dyck, Mishara & White, 1998; Joffe & Offord, 1983; Matter & Matter, 1984; Mishara, 1999; Orbach, Feshbach, Carlson & Ellenberg, 1984; Pfeffer, 1997) agreed about the phases of development through which children progress as they develop and mature in their understanding of death: 1) ignorance of the meaning of death; 2) death is a temporary state and is personified; 3) death happens to others; 4) death exists but attempts are made to keep it distant from self; 5) death happens to self. However, interestingly, these same researchers cannot agree upon the ages at which children go

through these phases. Each observes or speculates that children will progress through the various phases at different age levels.

The researchers' understanding about the development of death concept in children seems to have evolved. In the 1970s and 1980s, researchers were consistent and congruent in their understanding and agreement that a child's understanding of the permanency of death occurred at approximately age ten to twelve. For example, Pfeffer (1981) discussed Piaget's child development theory in describing the development of death understanding in children and applied the theory to suicidal children. Joffe and Offord (1983) noted that suicidal children see death as transient and pleasant but not permanent. Matter and Matter (1984) concluded that children cannot conceive of death as permanent and irreversible. Barker (1990) indicated that many younger children do not understand the finality of death, and that their concept of what it means to die may differ markedly from that of adolescents.

However, as research continued into the 1990s, with more focus specifically in the area of cognitive development of death understanding in children, it began to highlight other conclusions. Herring (1990) noted adults' common but mistaken belief that children do not comprehend the meaning of death. Normand and Mishara (1992) argued that the more experiences children have with death and the more refined their conceptions about death, the better they seem to understand suicide. In 1997, Pfeffer concluded that, although young children may believe death to be temporary, they do have concepts of death and are capable of effecting a self–destructive method to cause death. In 1999, Mishara noted that, "Researchers generally agree that children's understanding of death develops gradually and changes over time . . . Even by grade one, the concept of

death was fairly well understood" (pp. 116-117). Thus researchers' understanding as to when and how children gain an understanding of death evolved from 1979 to 1999, from a belief that children understand their own death by age ten, to a belief that children understand their own death by age five or six.

To summarize, for a child to develop death understanding cognitively and affectively, the child must have direct experience with a death and with the way in which the caregiver explains that event. It appears that experiencing the death of a loved one or a cherished pet brings home the "reality" of death, its finality in terms of physical cessation as well as the end of interactions with the dead individual. This reality has a major impact on a child's understanding of death, which can no longer be denied but only struggled with while the child achieves a new internal balance.

As for caregivers and parents, their honesty, straightforwardness and reassuring manner are vital in assisting children to come to terms with death (Kastenbaum, 1992). It is helpful for parents to understand that children do not think, feel, or see the world as adults do; they think, feel and see the world for themselves. Parents need to recognize children's desire to discuss aspects of their environment that confuse and frighten them. Shielding children from those who are dying or dead may only serve to derail or prolong the healing process. Children understand their environment and their experiences in ways that many adults do not want to acknowledge, fearing loss of innocence for the children.

Children appear to proceed from little or no understanding of death to a realistic understanding of the concept. Although children generally experience these stages in chronological order, an individual child may well deviate from the behaviour associated with a particular age range. Development involves much more than simply growing

older. Environmental support, behaviour, attitudes, responsiveness of adults, self-concept, intelligence, previous experiences with death, and a number of other factors play important roles in the individual child's development of an understanding of death.

Death Understanding and Suicide Risk Level

The literature reviewed explores the connection between death understanding and level of risk for suicidal behaviour. Normand and Mishara (1992) found that children do not resist talking about death and suicide, that children as young as seven can know the meaning of the word "suicide," and that by age eleven, almost all children understand the concept of suicide:

> Children are generally not traumatized when they are encouraged to talk about death and suicide and, perhaps surprisingly to some, 10 percent of first graders [ages 6 to 7], 50 percent of third graders [ages 8 to 9], and 95 percent of fifth graders [ages 10 to 11] have a certain understanding of suicide; 5 percent of the children from this sample personally knew someone who had committed suicide. (p. 183)

Mishara (1999) states that, "Children develop detailed knowledge of suicide early in life and … development of the concept of suicide is related to the development of the concept of death . . . and is related to the experiences with death" (p. 105). Kestenbaum, (1992), Mishara (1999), Pfeffer (1984), and Stefanowski-Harding (1990) all conclude that suicidal children believe that death is temporary and pleasant, whereas non-suicidal children perceive death as more permanent. They confirm the importance of a child's belief that his or her own death is a permanent state as a deterrent force against suicidal behaviours. Conversely, if a child considers death to be temporary or pleasant, he or she

may be more inclined to take suicidal action. Death concepts and preoccupations in children fluctuate and are affected by the child's ego state. Therefore, children who are under great stress may regress in their cognitive understanding of the finality of death, to the point where they view death as reversible and thus are at higher risk for suicidal behaviour. Consequently, it is not the age-predictable stage of development that is important in assessing suicidal risk, but rather the actual level of the child's understanding at the time of assessment. Suicidal children have been found to be significantly more preoccupied with thoughts of their own death than are non-suicidal children.

It is important that adults who work with children not view, treat, or approach them as if they were adults. They must acknowledge the differences between children and adults. For example, children's understanding of time and its sequencing is very different than that of adults (Orbach, 1988). A five-year-old child experiences a year as one fifth of his or her life, while a forty-year-old adult experiences a year as one fortieth of his or her life. Also children view the world in larger dimensions simply because they are smaller in stature. Children apply a literal approach to the world, whereas adults' approach tends to be more abstract and complex. All these aspects must be taken into consideration when adults are exploring a child's world and how he or she makes sense of experiences.

Professionals' Reluctance to Acknowledge Suicidal Children

The literature reviewed discussed the problem that many "hidden" suicides are never recorded. A child who suddenly runs into oncoming traffic is hit by a car and instantly killed; a child is found drowned in a pond with stones she has "collected" in her pocket to take home; a child "accidentally" shoots himself when "playing" with his

father's gun; a five-year-old girl drinks poison "by accident" from a kitchen cabinet. All are noted as "accidents" on the death certificates. Mishara's (1999) discussions with coroners and medical examiners reveal one explanation:

> Coroners are often reluctant to classify self-inflicted deaths in children as suicides because there is a general belief that children do not fully understand the implications of their actions and thus may be incapable of committing suicide, even when their self-inflicted injury or lethal behaviour resulted in death. (p. 106)

McGuire and Ely (1984) add that, "The fact that young children do not often write suicide notes compounds this difficulty, for notes are one chief category of evidence that coroners use to verify suicide" (p. 19).

In 21.7 percent of the literature reviewed, authors noted that many professionals do not want to acknowledge or have difficulty acknowledging suicidal tendencies in children. The very thought that some young children have suicidal thoughts and can commit suicide is too painful for many adults to face. Furthermore, the shock, denial and aversion evinced by people who have been asked to consider early childhood suicide tend to stand in the way of their clarifying and carrying out measures to prevent children from solving their problems by harming and/or killing themselves (Appleby, 1994; Greene, 1994; McGuire & Ely, 1984; Robinson, 1984; Sattem, 1990).

Another concern noted in the literature was the fact that both parents and medical professionals frequently identify suicide attempts as "accidents" (Joffe & Offord, 1983; Orbach, 1988; Pfeffer, 1986). This clearly illustrates the professional world's reluctance to acknowledge the reality that children want to, can, and do kill themselves (Banister,

1995; Charles & Matheson, 1988; Dugan & Belfer, 1989; Ginn, Range & Hailey, 1988; Greene, 1994; Mishara, 1999).

In my work as a suicide prevention trainer, I constantly come into contact with professionals who resist learning about suicide and suicide prevention/intervention strategies. Professionals who believe that they should have suicide prevention and intervention skills, and yet know they do not, may be unable to admit the problem to others because they feel they would be admitting a lack of skill. I believe that this lack of recognition significantly reduces support to the surviving bereaved family, which can only reinforce the practice of underreporting suicides of children.

Inconsistency in the Age Range of Suicidal Children

Throughout the research literature, the definition of "child" varied significantly. Stiles and Kottman (1990) defined children as aged 9 to 14. Ginn, Range, and Hailey (1988) and Valente (1983) defined children as aged 5 to 14, while McGuire and Ely (1984) and Peterson et al. (1996) defined them as aged 2 to 15 years. As a result, the definition of "child" is unclear and inconsistent in the literature. Research cannot be accurately cross referenced when the age range of the individuals of the study varies, even though the focus of the research may be similar, for example, risk factors for children who are suicidal.

Approximately 43 percent of the literature reviewed used the age range of five to twelve years. Therefore, for the purposes of this study, children are defined as individuals between the ages of five and twelve years of age. This definition excludes "toddlers," "babies," and "infants," that is, individuals four years of age and under who have limited mobility and only basic developmental cognitive ability. When a person turns thirteen,

our society generally considers the person a "teenager" or "adolescent" and no longer a "child"; hence literature focused on adolescents and adults was excluded from the study.

Table 3. Age Range of Children in the Literature

Age Range	% of Studies
0 to 12	50.0%
5 to 12	42.6%
0 to 15	35.3%
0 to 18	2.9%
No age provided	11.8%

Risk Factors Associated with Suicidal Children

Risk factors associated with suicidal children were discussed extensively in the literature. Information concerning the risk factors identified for suicidal children remained much the same over the years. For example, Glaser (1971), Pfeffer (1979), and Shearer (1972) identified separation, loss, anxiety, depression, stress, and reckless behaviour as some of the key risk factors for professionals to monitor when assessing suicidal children. These same risk factors were noted years later by Dyck, Mishara and White (1998), Pfeffer (1993), and Stillion and McDowell (1996).

The risk factors most frequently mentioned in the literature were assumed to be the most important, because researchers write about the risk factors that are strongly revealed during their studies. Many of the selected articles discussed more than one risk factor that emerged during the course of research. Table 3 identifies the 11 factors mostly widely accepted as risk factors in the literature. These cannot be fully summarized, because most articles addressed multiple risk factors.

Table 4. Suicide Risk Factors for Children

Suicide Risk Factors	% of Studies
Child Characteristics	
• Depression	48.5%
• Significant loss	30.9%
• Aggressive behaviour	29.4%
• Stress	29.4%
• Hopelessness	23.5%
• Previous attempts	20.6%
Family Characteristics	
• Family discord and violence	54.4%
• Poor and/or dysfunctional parent-child communication and bonding	30.9%
• Physical abuse	26.5%
• Parental separation/divorce	26.5%
Environmental Factors	
• Academic difficulties	22.1%

The noted risk factors identified in the literature can be divided into three broad areas. The first area of risk factors focuses on the child and the behaviours that the child displays, expresses, or acts out when suicidal. The literature refers to the reactions of a child in response to the surrounding environment.

The second area of risk factors focuses on the immediate environment of the child, the family context. This may not necessarily be the biological family but a foster,

adoptive, or chosen family environment. Family environment plays a key role in the reactions and behaviours of the child and the stress that can precipitate suicidal tendencies. Keeping these two areas separate, the child and the family environment, was key to sorting out all of the information surrounding the suicidal child. Often suicidal thoughts and behaviours are a direct response to the cumulative effect of both environmental stress factors and ineffective coping strategies of the individual. One first needs to determine the environmental factors and then to determine how the child is responding to these environmental factors. Determining the child's perception of his or her experience within their environment is critical in assessing the risk factors for suicide (Michalik-Bonner, 1990; Sokol and Pfeffer, 1992).

The third area of risk factors noted in the literature focuses on socio-environmental factors, such as peer relationships in school, academic performance, and stories of suicide appearing in the media (Herring, 1990), and the impact of these factors on children.

Each risk factor, although analytically distinct, is intertwined with all the other risk factors. Together the risk factors are like a set of keys on a ring; each key (or risk factor) is unique and separate, and yet collectively they create a single ring of factors that may identify a suicidal child.

Family Discord and Violence

Family discord and violence were noted in 54.4% of the literature reviewed as a risk factor in relation to suicidal children (for example, Asarnow, 1992; Crook & Raskin, 1975; Greene, 1994; Herring, 1990; Kestenbaum, 1992). Family discord has many aspects and incorporates dysfunctional interactions between family members, particularly

the parents, who ideally ought to represent stability and safety to children. Family discord may include conflict, hostility, arguing, physical or sexual abuse, parental psychiatric disorder, and parental suicidal behaviour (Pfeffer, Klerman, Hurt, Kakuma, Peskin, & Siefker, 1993). Family conflict is defined by descriptors such as anger, ambivalence, rejection, alcohol or drug abuse, insensitivity to each other's needs, and significant communication difficulties.

Children, who lack life experience, view the world in concrete terms and have a limited sense of time, view conflict in their family as extreme, long standing and permanent (Herring, 1990). Parental violence produces in a child the wish to escape from the intolerable interactions of the parents. As a result, the child regards himself or herself as bad, hostile, destructive, and worthless. Eventually the child may come to believe that he or she is expendable. Dugan and Belfer (1989) also note that when children feel incapable of having an impact on the family discord, they may use suicide as a desperate last-ditch effort to coerce or affect those who threaten their wellbeing. Killing oneself becomes a response to the intolerable weight of major discord in the relationships between family members. Paulson, Stone, and Sposto (1978) state that, "It is evident that a family that lives by violence can die by violence" (p. 233).

Depressive Symptoms

Of the literature reviewed, 48.5 percent noted depression as a risk for suicidal behaviour in children (for example, Greene, 1994; Kestenbaum, 1992; Livingston & Bracha, 1992; Marciano & Kazdin, 1994; Mental Health, 1999; Pfeffer, 1984; Stillion & McDowell, 1996). Only qualified professionals such as physicians or psychiatrists can diagnose depression. In the *Diagnostic and Statistical Manual of Mental Disorders,* the

American Psychiatric Association (1994) described several types of depression that can be diagnosed, including bipolar I and II, cyclothymic, dysthymic and major depression. The *Manual* distinguished between a depressive reaction caused by a trauma and that caused by a significant loss. While it is important to keep in mind the symptoms of depression -- changes in eating and sleeping patterns, reduction in concentration, poor affective responses and/or significant mood swings -- the use of the term "depression" in its diagnostic meaning should be avoided. For purposes of simplicity and clarity, the term "depression" as used in this study comprises the full range of symptoms surrounding depression and not the diagnosis of depression itself.

Significant Loss

Significant loss was noted as a risk factor in 30.9 percent of the literature reviewed. "Loss" pertains primarily to the death of a parent, loved one, or beloved pet. Within this category, the definition was expanded to include the removal of the child from the biological home into a residential/foster home, a move to a new community, loss of friends, or any event resulting in the child having no access or restricted access to someone or something he or she perceived as supportive and loving (for example, Dyck, Mishara & White, 1998; Matter & Matter, 1984; Nelson & Crawford, 1990; Pfeffer, 1979, 1985; Robinson, 1984). Loss due to the divorce or separation of the child's parents was not included in this category because the literature reviewed identifies divorce/separation as its own unique category, as discussed later.

It appears that the death of a parent or significant caregiver disrupts the stability that a child has and requires within the family environment. This is deemed a major contributing factor to childhood suicidal behaviours (Greene, 1994; Rosenthal &

Rosenthal, 1984). The disruption causes a child to perceive that the family is providing a significantly lower level of support. Often in the state of unsettlement due to the death or loss of one parent, the traumatized grief response of the remaining parent or significant other prevents that person from being supportive to the child. Adults who are not coping well themselves may not recognize that their child is in danger (Appleby, 1994; Orbach, 1986). This results in a lack of communication with and hence clarification for the child, who may fantasize about death as another form of life where the longing and love for the absent parent can be fulfilled (Orbach, 1984). In addition, Orbach (1984), Kosky (1983), Stiles and Kottman (1990) noted that suicide attempts frequently occur soon after the death of a loved one. Possibly the child is trying to reunite with the person who has died. The experience of loss can never be underestimated in relation to a child's experience of his or her environment; it must be explored fully with the child.

Poor or Dysfunctional Parent-Child Communication and Bonding

Poor and/or dysfunctional parent-child communication and bonding was noted in 30.9 percent of the literature as a suicide risk factor for children (for example, Adam, 1986; Joffe and Offord, 1983; Kosky, Silburn and Zubrick, 1986; Michalik-Bonner, 1990; Sokol and Pfeffer, 1992; Stefanowski-Harding, 1990). Asarnow (1988) discussed how a suicide attempt, although a desperate act, could be perceived as an attempt to communicate, to voice the child's pain, and to be heard, as well as to try to gain some control over the situation.

Sometimes a child is given the role of spouse replacement, especially after a death or divorce. Then, often unknowingly, the single parent may share thoughts and worries with the child and impose responsibilities which are beyond the child's maturational and

skill level. Incapable of viewing the issues from an adult perspective, the child may develop feelings of failure and inadequacy and at times overwhelming guilt for being unable to fulfill the parent's expectations (Glaser, 1971).

Kosky, Silburn and Zubrick, (1986) determined that children with suicidal ideation are more likely than nonsuicidal children to have disturbances in child-father and child-sibling relationships. Child-mother relationships showed a high level of disturbance characterized by persistent discord, and the child was more likely to suffer from persecution, hostility and child abuse. Undoubtedly, considerable emotional stress is exerted on the child by this adverse environment.

Joffe and Offord (1983) noted that a disturbed parent-child relationship is one of the main causal factors in childhood suicide and suicidal behaviour. McGuire and Ely (1984) discussed evidence that lack of emotional support early in children's lives can be severely exacerbated by having a suicidal parent or sibling, and further compounded by a long history of fighting between parents, disruptions in family life because of death or divorce, alcoholism, physical abuse, and even poverty. All these factors bear heavily upon a child, who is often simply an innocent bystander. Because this innocent bystander is yelling for help but not being heard, the child speaks as loudly as possible by taking his or her life.

Aggressive Behaviour

Aggressive behaviour as expressed by a child was noted in 29.4 percent of the literature as a suicide risk factor (for example, Carlson, Asarnow & Orbach, 1987; Myers, Burke & McCauley, 1984; Paulson, Stone & Sposto, 1978; Pfeffer, 1984, 1997; Powers, 1987; Rosenthal & Rosenthal, 1984). Aggression, hostility, and anger are all similar

emotions belonging to the same "family" of feelings. Feelings are experienced and expressed based on a continuum of intensity. We "feel" joyful more than we "feel" happy. We "feel" more hostility than anger. We "experience" more energy in our bodies and hence more intensity in the emotion. We become more "consumed" by the feeling of aggression, than when we feel angry. Therefore, when a child has not been taught or does not have a parental role model for dealing with the energy of anger in healthy and appropriate ways (Sturman, 1985), the child can express the anger towards others (by bullying, for example) or towards himself or herself (by suicide).

Powers (1987) noted that suicidal children often experience moods vacillating between anger and violence to others as well as grief. A child's mood can quickly swing from depression (anger turned inward) to violence against others (anger turned outwards). Pfeffer, Plutchik and Mizruchi (1983) discussed the view that assaultive and suicidal behaviours are produced by different sets of variables. They noted that it was important to determine the suicidal or assaultive potential of the child, and that one must assess the environmental stresses, the types of emotional expressions, and any evidence of assaultive or suicidal behaviour of the parents as major contributors to the risk. Although some suicidal children show intense depression, other suicidal children exhibit relatively less depression but show very intense aggression. It is critical to understand the emotion of anger and to recognize that not all suicidal children are predominantly depressed (Pfeffer, Plutchik, & Mizruchi, p. 157). Violence begets violence. As Linn and Linn (1978) stated, "Anger must be dealt with or it will deal with us" (p. 108).

Stress

Stress was noted in 29.4 percent of the literature reviewed as a risk factor associated with suicidal children (for example, Asarnow, 1992; Cohen-Sandler, Berman & King, 1982; Dugan & Belfer, 1989; Matter & Matter, 1984; Pfeffer, 1985). Cohen-Sandler, Berman and King (1982) noted that, "From the time suicidal children were 8.5 years old, they experienced significantly greater stress than did non-suicidal children" (p. 182). All life events produce stress. Stress results from such events as the birth of a sibling, the death of a loved one, the move to a new school or community, beginning or ending a boyfriend/girlfriend relationship, or anything that changes the environment around the child. Although the change can be experienced as a positive or negative event, any change or uncertainty in the environment produces stress. Often children do not receive training and support from their parents in how to cope with problems, uncertainty or changes in the environment (Matter & Matter, 1984; Sturman, 1985). Asarnow, Carlson, and Guthrie (1987) determined that, compared with non-suicidal children, children with suicide ideation were significantly less likely to generate active healthy coping strategies. A lack of coping ability adds to the stress experienced by a child who is already in an unstable family environment. Lack of support from parents or other adults in the child's life, compounded with the sense of isolation within the family circle, can induce several self-destructive reactions, including suicidal behaviours (Orbach, 1986).

Physical Abuse

Physical abuse was noted as a risk factor in approximately 26.5 percent of the articles reviewed (for example, Dugan & Belfer, 1989; Marr & Field, 2001; Orbach, 1984; Pfeffer, Kerman, Hurt, Kakuma, Peskin & Siefker, 1993; Robinson, 1984). The

parameters for defining physical abuse included physical assaults not only at home but in the school environment as well, through "bullying." The BC Ministry of Children and Families (1998) defined abuse as follows:

> A deliberate, non-accidental physical assault or action by an adult or significantly older or more powerful child that results or is likely to result in physical harm to a child. It includes the use of unreasonable force to discipline a child or to prevent a child from harming him/herself or others. The injuries sustained by the child may vary in severity and range from minor bruising, burns, welts or bite marks to major fractures of the bones or skull, and, in its most extreme form, the death of a child. Physical assault is a crime. (p. 7)

Orbach (1984) reported that suicidal behaviour was significantly higher in physically abused children (40 %) than in neglected children (17 %) and normal children (6%), and that the effects of physical abuse were cumulative (p. 44). Myers, Burke, and McCauley (1984) determined that domestic violence, especially that involving biological parents, discriminated the suicidal children from the non-suicidal children in their study (p. 479). Kosky (1983) reported that 60 percent of the suicidal children in his research group had been physically abused by their parents (p. 463). It is apparent that as children are "beaten" down, their sense of who they are, their sense of importance and value, diminishes as each incident occurs. Children see the world and adults as larger than themselves, and their sense of powerlessness, helplessness and expendability is confirmed time and time again (Joffe & Offord, 1983). In other words, many children are beaten to the point that they experience spiritual and emotional death, and then finally their own physical death by suicide.

Bullying on the school grounds causes no less than 16 children to commit suicide annually in the United Kingdom (Marr & Field, 2001). These authors state that coroners often record accidental death or misadventure on death certificates, because the circumstances are not sufficiently clear to meet the "beyond reasonable doubt" criteria for a suicide classification. Therefore the "true" total of suicidal deaths is covered up and placed in other classifications. Each "bullycide" is another example of a child dying as a result of the deliberate action of another, in an environment where the responsible adults (often teachers and parents) have failed to provide intervention to stop the physical and/or psychological violence. The excuses "We didn't know" or "We didn't understand" are no longer valid. The safety of children often rests in the hands of adults who place those same hands behind their backs, say nothing but "Boys will be boys." The result could be a child's death.

Parental Separation and/or Divorce

Parental separation and/or divorce were noted in 26.5 percent of literature reviewed as a suicide risk factor (for example, Dyck, Mishara and White, 1998; Matter & Matter, 1984; Nelson & Crawford, 1990; Pfeffer, 1979, 1985; Robinson, 1984). Although this risk factor was connected with the risk factor of loss, for a divorce is the loss of a parent in the child's immediate environment, its significance warranted separate identification in the literature reviewed.

What is more important here than the actual divorce or separation of the parents is how the parents cope with, handle, and discuss their separation with their children. Is there major conflict between them? Are they using the children against each other? Is one of the parents refused access to the children? Is one of the parents choosing not to be

involved with the children? Two key issues are intertwined with this risk factor for children. Conflict between the parents places significant stress on the children, especially if there is a custody battle. The conflict may include one parent speaking negatively about the other parent in front of the children, trying to have the children choose one parent over the other, identifying one parent as right and the other as wrong, buying the child gifts in an attempt to "buy" loyalty to one parent, or attempting to appease a parent's sense of guilt. The second issue in relation to divorce or separation is the vacuum that is created when one parent leaves the home environment. Although domestic violence may have been part of the family experience prior to the separation, children's loyalty to the family is extraordinary and cannot be discounted or go unacknowledged. As Powers (1987) noted, the family may be highly dysfunctional before, during, and after the separation process, but suicidal children remain strongly bonded and loyal to the family.

My experience in child protection confirms this evidence. I frequently noted that, although children may have been abused, they clearly continue to love the abusive parent although they hate the behaviour. Often children share their love for the parent even in horrendous circumstances. Children often demonstrate astonishing resiliency in loving their parents amidst chaos. Both parents play significant roles in their children's lives: creating a safe environment, answering questions about frightening life situations, and providing comfort and stability in time of need. When children do not have a sense of being in a safe environment, their stress, confusion, and fear can rise to critical and even suicidal levels.

Hopelessness

Hopelessness was noted as a risk factor in 23.5 percent of the research literature reviewed (for example, Eth, Pynoos & Carlson, 1984; Marciano & Kazdin, 1994; Michalik-Bonner, 1990; Milling, Campbell, Bush & Laughlin, 1992; Pfeffer, 1997). Pfeffer (1997) defined hopelessness concisely:

> Hopelessness involves the perception that current difficult circumstances will be maintained with little likelihood of a change for the better. This perception may lead to pressures on self-esteem regulation and promotion of poor self-concepts, notably low appraisal of one's social competence and intensification of feelings of shame and guilt. (p. 554)

Hopelessness combined with a lack of coping strategies can form a deadly combination that may result in a child succumbing to suicidal impulses. Hopelessness has a way of undermining a child's sense of what is right in the world and, if unchecked, can foster helplessness. It is critical to examine not only the level of hopelessness, but also the child's sense of helplessness and repertoire of coping strategies.

Academic Difficulties

Academic difficulties were the most noted suicide risk factor that went beyond the child and the family context, and into the socio-economic environment. One could argue that this risk factor is within the context of the child. However, because the school environment plays a key role in the academic life of the child, it is important to take into account school marks, helpful versus unsupportive teachers, a poorly funded school versus a more affluent school, a culturally sensitive versus a more judgmental school, and other considerations (Herring, 1990; Larsson & Melin, 1992; Nelson & Crawford, 1990;

Pfeffer, 1984). When a child is not doing well academically, it may mean that an issue for the child has not been addressed. Issues may include as an inability to hear (partial deafness) or see a teacher's instructions (nearsighted vision), an undiagnosed learning disability such as dyslexia, lack of concentration due to fear of being bullied or family violence at home, a parent's erratic behaviour due to mental illness, an undiagnosed mental illness/disorder of the child (for example, attention deficit disorder or depression), hunger (a hungry child cannot concentrate on learning), and many others. In other words, nothing can be assumed about a child's world experience. The teacher and/or counsellor must learn about the child's world directly from the child.

Prior Suicide Attempts

Although the factor of prior attempted suicides was mentioned in only 20.6 percent of the literature, it was noted to be a key predictor identifying children at high risk for committing suicide (Asarnow, Carlson & Guthrie, 1987; Dyck, Mishara & White, 1998; Herring, 1990; Horowitz, Wang, Koocher, Burr, Smith, Klavon & Cleary, 2001; Livingston & Bracha, 1992; Shearer, 1972). Approximately 10 percent of child suicide attempts will ultimately succeed (Herring, 1990, p. 129). O'Carroll et al. (1996) define a suicide attempt as follows:

> A potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence (either explicit or implicit) that the injury was self-inflicted and that the person intended at some … level to kill himself/herself. A suicide attempt may or may not result in injuries. (p. 247)

An unfortunate aspect of child suicide attempts (with or without injuries) is that the family often remains "silent." Children seldom call crisis hot lines, tell family

members, or seek out adult supports, such as a school counsellor. On the contrary, children tend to pledge their friends to secrecy over the attempted suicide. The silence that surrounds a child's suicide attempt provides insight into a family environment that does not hear a child in distress or is unable to respond with appropriate support.

Children who have experienced the suicide of a close family member are nine times more likely to take their own life (Herring, 1990, p. 131). Dyck, Mishara, and White (1998) expanded the risk factor to include suicide attempts not only by close family members but also by relatives; these significantly increase the risk of a child taking his or her own life. Pfeffer, Normandin, and Kakuma (1994) noted that 50 percent of the mothers of child suicide attempters reported that they themselves had attempted suicide. Pfeffer, Hurt, Kakuma, Perskin, Siefker, and Nagabhairava (1994) suggested that children who have a history of suicidal ideation or who have made a suicide attempt are at significant risk for a recurrent episode of suicidal ideation or a suicide attempt, especially within two years of psychiatric hospitalization.

As a risk factor for children, suicide attempts have far-reaching implications and must be examined in detail, from the child's history to the caregiver's parenting skills and coping style, to the history of the whole family. The child must be assessed within a family context, and the family must be assessed within the context of a suicidal child. The child's personal and family history must be taken. It is critical to assess the individual child and not just to conduct an assessment based upon the family or the parents' perspective of their child. The two components must be completed separately, and both must be done to safeguard not only the child but the other family members as well. Finally, Valente (1983) reminds us that when a child is preparing to kill himself or

herself, the child often becomes clear of mind and in this state of clarity is at greater risk for committing suicide.

Teachers represent another significant adult role influence for a child; all too often, they are the only listening adults in a child's life. Rosenberg and Latimer (1966, cited in McGuire & Ely, 1984) emphasized that "School is the first place, outside the home, in which children's strengths and difficulties can be observed" (p. 24). Rosenberg and Latimer (cited in McGuire & Ely, 1984) recommended that teachers should more actively refer symptomatic children to other school and community resources (p. 24). However, as Cohen-Sandler, Berman and King (1982) discovered, referrals to mental health services by school personnel represent approximately 23 percent of nonsuicidal children and account for no suicidal children at all (p. 180). This finding suggests that referrals to community mental health services by school personnel do not occur, when children are displaying suicidal behaviours.

Peterson, Zhang, Santa Lucia, King and Lewis (1996) argued that child suicide ideation and attempts may represent an early warning system for adolescent completed suicides:

> [The] frequency distribution also suggests that the age-related increase in risk for suicide attempt, which begins at about 11 years of age, is several years later than the age at which the risk for suicidal ideation begins to increase. Children who present with suicidal ideation at this relatively younger age may be an important target population for intervention measures aimed prevent future suicide attempts. (p. 1168)

In other words, young children under eleven years of age may begin thinking of suicide; as they grow into adolescence, their suicidal ideation may intensify into suicidal attempts and eventually into a completed suicide in their adolescent years. Pfeffer (1997) supported this view that children with suicidal thoughts could grow into suicide-attempting and suicide-completing adolescents: "Prepubertal suicidal ideation imparts approximately six times the risk for a suicide attempt in adolescent and prepubertal suicide attempts impart approximately four times the risk for a suicide attempt in adolescence" (p. 558). Pfeffer emphasizes the need to develop awareness that children do think about suicide, can be suicidal, and may grow into adolescents who commit suicide.

Identified risk factors are not necessarily predictors. Neither the severity of the problem nor the combination of events and behaviours will necessarily determine that a child will attempt suicide. The precipitating factors are still unclear, and it is a fact that children who seem to have identical problems often behave differently. The most useful way to apply what is known about pre-suicidal conditions is to use them as an alerting system (McGuire & Ely, 1984; Pfeffer, 1986; Orbach, 1988). An alerting system contains three components: it requires knowledge of the predominant risk factors associated with suicidal children; it involves training to acquire skills on the initial intervention of a suspected suicidal child; and it requires knowledge about community resources to ensure that the suicidal child and the family have access to appropriate support intervention.

Gender

The aspect of gender in relation to child suicide was discussed only in passing in the literature reviewed for this study (Langlois, 2002; Pfeffer, 1986). There is a marked difference in the rates of suicide and suicide attempts between adolescent boys and girls.

Adolescent boys are three times more likely to commit suicide than adolescent girls, while adolescent girls are 1.5 times more likely to attempt suicide than adolescent boys (Langlois, 2002, p. 9). Pfeffer (1986) found similar results:

> The degree of severity of suicidal behaviour along the spectrum of suicidal ideas, threats, or attempts is not different for boys and girls....This finding is different than for adolescents. Among adolescents, boys commit suicide more frequently than girls, but girls attempt suicide more frequently than boys. (p. 37)

Summary

The findings, themes, trends and controversies that emerged from the literature can be summarized as follows:

1. It is difficult to define the term "suicide" (and its derivatives) and even more difficult to include children in the definition.
2. There is an ongoing evolution of professional understanding regarding at what point children understand the concept of the permanency of death in relation to themselves.
3. Professionals working with children are often unwilling to acknowledge the reality that children have suicidal tendencies and can commit suicide.
4. The inconsistency of the age range used to define children hinders research from being accurately cross referenced and compared.
5. Over half of the literature reviewed cites family violence as the primary risk factor associated with suicidal children.
6. Depression is the second most cited risk factor concerning suicidal children in the literature reviewed for this study.

7. A practitioner's guideline for qualifying childhood suicidality should include questions concerning the following risk factors: family discord and violence, depression, significant loss, aggressive behaviour, stress, hopelessness, previous attempts, poor and/or dysfunctional parent-child communication and bonding, physical abuse, parental divorce or separation, and academic difficulties.

Chapter 3. Disseminating Findings from the Research Literature to the Suicide Prevention/Intervention Professional

One intention of this study is to gather and summarize into one document the research conducted on suicidal children, so that professionals do not need to gather and read all the research information themselves in order to apply extensive academic research and knowledge to their working situations. In other words, professionals will benefit by having access to a study that condenses the current research literature into a digestible form and guidelines. The guidelines identify risk factors and contextual variables in one form that suicide prevention/intervention professionals can use to organize their notes, with some assurance that they will not be missing some vital component. It is critical that research information be effectively disseminated to those who work in the frontline.

To emphasize this point further, I want to discuss the work conducted by David Goldston. In 1999, Dr. Goldston was commissioned by the United States National Institute of Mental Health to review all instruments used to assess suicidal behaviours and risk among youth. The need for such a review came to light for the third time in March 1999, when individuals from the National Institute of Health Office of Rare Diseases and the American Foundation for Suicide Prevention and the National Institute of Mental Health sponsored a workshop titled "Treatment Research with Suicidal Patients." The participants at this workshop identified that one of the problems inherent in research studies stemmed from the lack of standard assessment instruments proven to be both reliable and valid (p. 7).

Goldston (2000) reviewed 68 diagnostic interview and/or instrument tools. For each diagnostic instrument, he described the potential usage, population best studied using the instrument, parameters used in the assessment and definition of suicidal behaviours, reliability, concurrent validity, and predictive validity. All 68 instruments were reviewed for strengths, weaknesses and usability.

The diagnostic tools were divided into three categories, depending on their focus on 1) children, 2) adolescents, or 3) both populations. Goldston also reviewed instruments that could be used on children and their parents; on adolescents and their parents; and on children, adolescents and their parents. Some instruments focused on mental health concerns such as depression or schizophrenia; others focused on suicidal thoughts and life attitudes. Goldston's is one of the best reviews of assessment tools to date. The study is concise, detailed and to the point.

Goldston summarized his findings into seven conclusions. Not surprisingly his first conclusion was the need for clinicians and researchers to use a common language to describe suicidal ideation and behaviours (p. 198). This finding clearly indicates that the lack of a common definition for suicide and suicidal behaviours hinders effective research and the development of effective assessment and intervention strategies.

Second, Goldston concluded that it should never "be assumed that different diagnostic and risk assessment instruments will always have same utility in differing population groups, just as it cannot be assumed that research findings are always generalizable across different populations groups" (p. 200). In other words, what may work as an assessment tool or a therapeutic approach for intervention with one population group may not be useful or appropriate when applied to another group. Therefore, the use

of different age ranges across the literature effectively prohibits cross comparisons and the development of effective assessment and intervention strategies with suicidal children. A fifteen-year-old's reactions and responses to life cannot be compared to a twelve-year-old's reactions and responses to similar life circumstances (Peterson et al., 1996). Therefore, the conclusions of research studies conducted on adolescents or adults cannot be applied to children.As Goldston stated, "When all is said and done, the reality is that it is much simpler just to ask individuals if they have attempted suicide in the past, rather than using some elaborate probabilistic system for guessing at these facts" (p. 199). Goldston notes that, rather than using an instrument to determine past suicide attempts, it is more important to determine who will attempt or complete suicide in the future: "There is no short cut – the only way to discover who is at risk in the future is to follow individuals thought to be 'at risk' over some significant period of time" (p.199).

Goldston's third conclusion identified the need to link certain risk factors, such as depression and hopelessness, to suicidal behaviours. As Goldston noted, there is not enough valid evidence to use such risk factors as depression and family discord as reliable indicators that correlate with an increase or a decrease in risk level for suicidal behaviours.

Goldston's fourth conclusion was that too many researchers and clinicians believe that, once someone has suicidal ideas or attempts suicide, suicide is inevitable; as a result, assessment tools are designed with this conclusion in mind. However, people do not always remain in a suicidal state. Many people become nonsuicidal when the environment or event that precipitated the suicidal ideation is resolved. In the absence of stressors, the suicidal ideation disappears.

Goldston's fifth conclusion supported the need for research to focus on suicidal children, and not on adolescents or the general population. Clinicians, teachers, and other professionals must utilize an approach that honours and acknowledges children and the fact that their approach to life is different from that of adolescents or adults.

The sixth conclusion stated that it is not enough to identify risk factors. It t is important to understand the significance of those characteristics in the context of suicidal behaviours, the family's interactive environment, and the child as an individual. Therefore, a risk factor means nothing without a context.

Goldston's seventh conclusion concerned the appropriateness of assessment measures for treatment research. Once again, Goldston challenged researchers to examine the practical side of research, how it will directly reduce suicides within the child and adolescent populations as well as provide reliable and valid intervention strategies.

O'Carroll et al. (1996), Goldston (2000), and Mishara (1999) call for suicidologist researchers to be more consistent in their definitions and approaches to the work, so that the field of suicidology may advance and provide solid information. In addition, they note that research is ineffective if it is not practical or directly applicable to frontline professionals. As Shneidman (1994) stated, "Effective suicide intervention depends on accurate assessment that, in turn, depends on meaningful definition" (pp. 6-7).

Development of a Practitioner's Guideline Qualifying Childhood Suicidality

The final step of this study involves the development of guidelines for suicide prevention and intervention professionals in qualifying childhood suicidality. The guidelines are designed for professionals, regardless of their disciplinary background, such as teachers, counsellors, social workers or psychologists who work directly with at-

risk children. The guidelines were developed based on the literature reviewed, which identified areas of consensus and disagreement, emerging trends, and the factors that are important in identifying suicidality in children.

The guidelines are discussed and described in two sections. Section One creates a context and foundation for the guidelines, in order to give professionals an overall basic understanding of how to utilize and apply the guidelines. Section Two, the guidelines themselves, identifies twelve areas that must be explored during the determination of the suicidality of a child. Professionals must explore and determine the child's level of suicidality using their own style and paradigm of work with clients. In this manner, they will be guided in their work of assessment and intervention with a suicidal child and his or her family, while remaining within their own frame of reference and training orientation. Therefore, the guidelines represent not an assessment tool but a guide that identifies areas requiring exploration in the determination of suicidality of a child within a family context.

Table 5 identifies the key aspects that emerged through the literature review, as discussed in Chapter Two. Each element is discussed in Section One or incorporated directly into Section Two, the guidelines.

Table 5. Qualifying Childhood Suicidality: A Practitioner's Guideline

Element Identified in Literature Review	Section One: Context	Section Two: Areas for Exploration
Suicide definition	X	X
Developing death understanding	X	
Death understanding and suicide risk level		X
Professionals' reluctance	X	
Age range		X
Suicide risk factors: family discord and violence, depression, significant loss, poor and/or dysfunctional parent-child communication and bonding, aggressive behaviour, stress, physical abuse, parental separation/divorce, hopelessness, previous suicide attempts, academic difficulties		X

The guidelines are structured to provide twelve risk factor areas, based on the literature reviewed, that require consideration and exploration when professionals are determining the suicidality of a child. Each area includes definitions, examples and some details to provide clarity, context and direction to the professionals as they explore the circumstances surrounding a suicidal child. The definitions and examples are drawn from the information presented in Chapter Two. They are included to provide professionals

with immediate support and clarity, to enhance understanding, and to suggest areas on which professionals might focus questions as they determine the suicidality of the child.

The guidelines are intended to complement the professionals' own intervention paradigms, how they interact and support change with clients. The guidelines are designed to provide a foundation and context while professionals are assessing a suicidal child and developing strategies of intervention and long term planning. Professionals must maintain their professional ethics and accountability guidelines as they incorporate the guidelines into their practice.

Context for the Guidelines Qualifying Childhood Suicidality

Professionals must take a number of factors or perspectives into consideration when applying the guidelines through the lens of their paradigm of work. It is critical that professionals have knowledge and training in the area of child development before they utilize the guidelines, for they must be able to conduct interviews with suicidal children using questions and statements that are understandable and age-appropriate to the child. In addition, they must be able to ask the same questions, using different words that are at the level of understanding of the parent(s) or caregiver(s) of the suicidal child. The guidelines are designed for use with the suicidal child and the child's family.

To complement the training in child development, professionals must also be trained in the basics of suicide prevention, assessment and intervention. They must keep in mind the fact that basic suicide prevention training often does not include strategies on working with suicidal children. Through training, professionals must examine the possibilities concerning their own fear and reluctance to acknowledge and work with suicidal children. This attitude can and will interfere with effective intervention if not

confronted and resolved by the professionals within themselves. Pfeffer (1986), Orbach (1988), Mishara (1999), and Goldston (2000) all indicate that assessments and interventions must honour and acknowledge the fact that children approach life very differently than do adolescents or adults. In other words, what may work for adolescents and adults may not, and in most cases does not, work with children.

The guidelines are designed for use within a family context, whatever "family" may mean. The traditional Mom, Dad and children all biologically related, or two gay men with children, or a single parent family, or a grandmother or aunt as the primary caregiver, or even the environment of a group home may all constitute a "family." What is important for the professional to consider is that "family" must be defined by the child. The guidelines can have far reaching implications and must be used to examine the family's intricate design, from the child's history to the caregivers' parenting skills and coping styles, to the history of the family as a unit. When working with children at risk, professionals must assess the child within a "family" context, and assess the family within the context of the suicidal child. Personal-family history must be taken. It is critical to assess the child himself or herself, and not just to conduct an assessment based upon the family's or caregivers' perspective of the child. Assessment of the child and the family must be completed separately, both in a manner that safeguards not only the child but all family members. Therefore, it is important to ask the questions that are outlined in the guidelines separately of the child and the caregivers, and then to compare the results.

Finally, the guidelines are structured to provide space for the reflective work of the professional. Each of the guidelines contains a "comment section" that allows the professional to note additional observations in relation to the subject area and to note

similarities and differences between the child's perspective and the caregivers' perspective. When differences are evident, additional exploration will be required to determine the cause of the differences; the professional may need to take into consideration child development issues as the cause of the differing points of view. Professionals utilizing these guidelines for documentation purposes are provided ample space for detailed note taking in the comment section.

The guide provides a definition key for each risk factor, based on the literature. Examples of the risk factor are also provided in order to clarify how the risk factor may manifest through the suicidal child's behaviour. The examples are not intended to be exhaustive, but to enhance understanding and provide direction for exploration.

It is critical that professionals view and assess each of the twelve risk factors not in isolation but as part of a "whole environment." The "whole" is greater than the sum of its parts. All the risk factors are interconnected like keys on a keyring, each factor contributing to a better understanding of the circumstances surrounding a suicidal child. Each risk factor must be considered as a separate issue, with the understanding that the more characteristics that present for each risk factor, the higher the child's risk is for suicidal thoughts and behaviour.

As the final process in determining the overall suicide risk level of the child, professionals must place the information gathered through the guidelines within their own experience and training. Overall, the guidelines are designed to put all the facts of the family environment into one place for a summary review of the family situation, in order to remove speculation, assumptions, and judgements. Professionals can then review the guidelines in their entirety and make their best decisions about the options for

intervention and the extent of intervention necessary for the safety of the child. The next step is determining a plan of intervention, based on the information gathered through the guidelines as well as the overall rating of low, mid or high risk.

In conclusion, it is important to remember that the identified risk factors are not necessarily predictors, and that neither the severity of the problem nor the combination of events and behaviours will determine without a doubt that a child will attempt suicide (Orbach, 1988; Pfeffer, 1986). Precipitating suicide risk factors are still shrouded in mystery, and it is a fact that children who seem to have identical problems behave differently.

Qualifying Childhood Suicidality: A Professional's Guide (see Appendix C) is designed to assist suicide prevention/intervention professionals in determining potential pre-suicidal conditions as an alerting system concerning at-risk children. It is intended for use by professionals in the field, who are taking notes as they gather information concerning the possibility of a suicidal child. The form is designed to guide professionals through the areas requiring exploration and clarification concerning the risk factors associated with a suicidal child.

Chapter 4. Discussion and Further Areas for Study

The evidence presented in this study clearly demonstrates that children can and do commit suicide. The full scope and magnitude of suicide among children remain incomplete due to the lack of clear definitions regarding suicidal behaviours, definitions that include children, professional interpretations, and professionals' apprehension about identifying children who are suicidal or who have committed suicide. The literature indicates that as many as 15 percent of normal school children harbour suicidal ideas or display suicidal acts (Carlson, Asarnow & Orbach, 1987). Stiles and Kottman (1990) state that, "About 200 suicides of children under the age of 12 are reported annually in the United States . . . [and] twenty-five thousand children are hospitalized . . . because they express suicidal thoughts" (p. 337).

This study focuses on the issues surrounding the definition of suicide and inclusion of children in the definition. One would think that the definition of suicide would be simple, for everyone "knows" what suicide is: one's own death caused by oneself. However, as has been discussed, suicide is a complex human behaviour with multiple layers of meaning. The surface may appear clear, but the depth remains murky.

Three key aspects, all interrelated, contribute to the murkiness of the definition of suicide in relation to children. The first is the requirement that individual children know that their behaviour will end their own life. The second involves the question of when children develop the ability to understand that they themselves can die and that they can commit an act that would cause their own permanent death. The third is the reluctance of professionals to acknowledge that children as young as five years of age have the ability to think about, attempt, and commit suicide.

The nomenclature for suicide-related behaviours presented by O'Connell et al. (1996) would be an effective definition if researchers and professionals working in the field of suicidology would agree upon two aspects. First, sufficient research has been presented that the phenomenon of children thinking and of committing suicide is real. I encourage all professionals working with children to acknowledge this reality, to receive training, and to listen and watch for children who are prone to suicidal behaviours. Professionals who are reluctant to accept the fact that children can and do commit suicide hinder the consistency in approach, understanding, research and treatment of suicidal behaviours by children.

The debate truly begins here. When exactly do children gain the knowledge and understanding that their death can be permanent? Some research clearly identifies that a child as young as six can develop the understanding of the permanency of death, while other research does not support this conclusion. In the end, how can this debate be resolved? Can it be resolved? Orbach (1988) states that, "Searching for theoretical hairs to split leads to unintentional neglect of the person, his world of experiences, and his attitude toward life and death" (p. 12), which may result in a suicide.

The study has laid out the risk factors that assist in identifying suicidal children: family discord and violence, depression, significant loss, aggressive behaviour, stress, hopelessness, previous attempts, poor and/or dysfunctional parent-child communication and bonding, physical abuse, parental divorce or separation, and academic difficulties. It is important for professionals to assess the suicide risk factors of the child while taking into consideration the child's surrounding environment, including the family, family history, current interactions between family members, and the coping skills that are

utilized and taught within the family unit. Identifying the risk factors for suicidal children is not enough. Knowing what might lead a child to take his or her own life is the first step towards intervention and prevention of completed suicides. Professionals must also be trained to believe that child suicides do happen, that there are known risk factors, and that, as a result, appropriate intervention can be engaged and lives saved.

However, as Cohen-Sandler, Berman and King (1982) discovered, referrals to mental health services by school personnel represent approximately 23 percent of nonsuicidal children and account for no suicidal children at all (p. 180). This statistic suggests that school personnel do not make referrals to community mental health services when children are displaying suicidal behaviours; it has major implications concerning how schools respond to suicidal children. Is the lack of response and referral to mental health services due to a lack of training of school personnel concerning the signs and symptoms of suicidal children? Do they believe that children are not capable of being suicidal or acting upon suicidal thoughts? Do they believe that schools are best equipped to manage suicidal children within their boundaries? The literature does not answer these important questions, and they merit further exploration.

Child Suicide Risk Assessments

Throughout the literature, suicide risk assessments for children are discussed only infrequently. However, two discussions of risk assessments exist (Larzelere, Andersen, Jorgensen, & Ringle, 2002; Pfeffer, Jiang, & Kakuma, 2000). Pfeffer et al. studied the use of a child-adolescent risk assessment. Although Goldston (2000) does not necessarily support an assessment tool for both children and adolescents, the tool itself is comprehensive enough to gather sufficient information to assess the suicidality of a child.

The assessment tool remains in the beginning stages, and its reliability and validity will be determined through careful application.

The child suicide risk assessment developed by Larzelere et al. (2002) appears to focus on children between the ages 6 and 12. However, its primary focus rests with the child and does not appear to take into consideration the family environment. As noted earlier, assessment of a suicidal child without assessment of the family is only half of an assessment and hence incomplete. My concern is that, although there are two assessment tools that are properly focused on children, they do not take into consideration the family context of the child. In the end, the development of a true child suicide risk assessment is necessary in light of the trends and controversies discussed in this study. It is vital that the two child suicide risk assessments receive support from the professional community, and that their validity and reliability be further explored and tested so that a child's suicidal behaviour can be appropriately assessed and an intervention strategy engaged. A child's life is at risk.

Further Research

This study has consolidated the current literature that focuses on suicidal children. Researchers need to work towards acceptance of the standard definition and nomenclature of suicidal behaviours proposed by O'Carroll et al. (1996). Further studies are needed that focus on children between the ages of 6 to 12, and statistical gathering must include this unique population group. Finally, researchers must continue to explore the development and effectiveness of child suicide risk assessments, building on the work of Pfeffer et al. (2000) and Larzelere et al. (2002).

In addition, researchers must begin the process of clearly identifying which characteristics of each risk factor are truly linked to suicidal behaviours and in what context. Goldston (2000) noted the need to link certain risk factors, such as depression and hopelessness, to suicidal behaviours; there is not enough valid evidence to use such risk factors as depression and family discord as reliable indicators correlated with an increase or a decrease in risk level for suicidal behaviours. Further investigation is needed in order to validate how family discord and violence, and the other risk factors identified in this study, contribute to suicidal behaviour.

References

Adam, K. S. (1986). Early family influence in suicidal behaviour. *Annuals New York Academy of Sciences, 487,* 63-76.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed. revised): DSM-IV-R. Washington, DC: American Psychiatric Association. Retrieved January 31, 2002, from Online Psychological Services at http://www.psychologynet.org/dsm.html

Appleby, M. (1994). *Understanding and helping suicidal children.* Retrieved January 31, 2002, from National Youth Suicide Prevention Strategy website: http://www.ysp.medeserv.com.au/course.cfm?IngResourcesID=38

Asarnow, J. R. (1992). Suicidal ideation and attempts during middle childhood: Associations with perceived family stress and depression among child psychiatric inpatients. *Journal of Clinical Child Psychology, 21*(1), 35-40.

Asarnow, J. R., & Carlson, G. (1988). Suicide attempts in preadolescent child psychiatry inpatients. *Suicide and Life-Threatening Behaviour, 18*, 129-136.

Asarnow, J. R., Carlson, G., & Gutherie, D. (1987). Coping strategies, self –perceptions, hopelessness and perceived family environments in depressed and suicidal children. *Journal of Consulting and Clinical Psychology, 55,* 361-366.

Ashworth, J. (2001). *Practice principles: A guide for mental health clinicians working with suicidal children and youth.* Victoria, BC: Ministry of Children and Family Development.

Baartman, H. (1994). Child suicide and harsh punishment in Germany at the turn of the last century. *Paedagogica Historica, 30*(3), 849-864.

Banister, K. (1995). Suicidal children: Assessment and treatment strategies. *Suicide Prevention Newsletter, 8*(4), 1-3, 6.

Barker, P. (1990). *Clinical interviews with children and adolescents*. New York: Norton.

British Columbia Ministry of Children and Families. (1998). *BC handbook for action on child abuse and neglect.* Retrieved May 16, 2003, from http://www.mcf.gov.bc.ca/child_protection/child_abuse_handbook/

Carlson, G. A., Asarnow, J. R., & Orbach, I. (1987). Developmental aspects of suicidal behaviour in children. *Journal of the American Academy of Child and Adolescent Psychiatry, 26,* 186-192.

Center of Disease Control. National Center for Health Statistics. National Vital Statistics Report. *Deaths, percent of total deaths, and death rates: United States, 2000-on.* (September 16, 2002). Retrieved January 18, 2003, from http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_13.pdf

Charles, G., & Matheson, J. (1988). Suicide prevention and intervention in child care programs. *Journal of Child Care, 3,* 39-50.

Clark, D. A. (1994). *Exploring the concept of suicide in children through stories: A case study approach*. Tallahassee, FL: Florida State University.

Cohen-Sandler, R., Berman, A., & King, R. (1982). Life stress and symptomatology: Determinants of suicidal behaviour in children. *Journal of American Academy of Child Psychiatry, 21,* 178-186.

Crook, T., & Raskin, A. (1975). Association of childhood parental loss with attempted suicide and depression. *Journal of Consulting and Clinical Psychologists, 43*(2), 227.

Cross, T. (1996). Examining claims about gifted children and suicide. *Gifted Child Today*, *18*(3), 46-48.

Dugan, T. F., & Belfer, M. L. (1989). Suicide in children: Diagnosis, management, and treatment. In D. Jacobs & H. N. Brown (Eds.), *Suicide: Understanding and responding* (pp. 201-220). Madison, CT: International Universities Press.

Durkheim, E. [1897] (1979). *Suicide. A study in sociology.* J. A. Spaulding & G. Simpson (trans.). New York: Free Press.

Dyck, R. J., Mishara, B. L., & White, J. (1998). *Suicide in children, adolescents and seniors: Key findings and policy implications.* Ottawa: National Forum on Health, Health Canada.

Evans, G., & Farberow, N. L. (Eds.). (1988). *The encyclopedia of suicide.* New York: Oxford.

Fitzgerald, H. (1992). *The grieving child.* Toronto: Simon & Schuster.

Flisher, A. J. (1999). Annotation: Mood disorder in suicidal children and adolescents: Recent developments. *Journal of Child Psychology and Psychiatry*, *40*(3), 315-324.

Freedman, A. M., Kaplan, H. I., & Sadock, B. J. (1975). *Comprehensive textbook of psychiatry* (Vol. 2) (2nd ed.). Baltimore, MD: Williams & Wilkins.

Fremouw, W. J., Perczel, M., & Ellis, T. E. (1990). *Suicide risk assessment and response guidelines.* New York: Pergamon.

Ginn, P. D., Range, L. M., & Hailey, B. J. (1988). Community attitudes toward childhood suicide and attempted suicide. *Journal of Community Psychology, 16,* 144-151.

Glaser, K. (1971). Suicidal children: Management. *American Journal of Psychotherapy, 25,* 27-36.

Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.). (2002). *Reducing suicide: A national imperative.* Retrieved April 21, 2003, from National Academy of Sciences web site: http://www.nap.edu/openbook/0309083214/html/376.html

Goldston, D. B. (2000). *Assessment of suicidal behaviours and risk among children and adolescents.* Technical Report submitted to NIMH under contract number 263-MD909995. Bethesda, MD: US National Institute for Mental Health.

Greene, D. B. (1994). Childhood suicide and myths surrounding it. *Social Work, 39,* 230-232.

Herring, R. (1990). Suicide in the middle school: Who said kids will not? *Elementary School Guidance and Counselling, 25,* 129-137.

Horowitz, L. M., Wang, P. S., Koocher, G. P., Burr, B. H., Smith, M. F., Klavon, S., & Cleary, P. D. (2001). Detecting suicide risk in a pediatric emergency department: Development of a brief screening tool [Electronic version]. *Pediatrics, 107*(5), 1133-1138.

Joffe, R. T., & Offord, D. R. (1983). Suicidal behaviour in childhood. *Canadian Journal of Psychiatry, 28,* 57-63.

Kastenbaum, R. (1992). *The psychology of death* (2nd ed.). New York: Springer.

Kestenbaum, J. (1992). *Suicidal versus non-suicidal children: Psychological, cognitive, psychiatric and family history differences.* Fresno, CA: California School of Professional Psychology.

Klimes-Dougan, B., Free, D., Ronsaville, D., Stilwell, J., Welsh, J., & Radke-Yarrow, M. (1999). Suicidal ideation and attempts: A longitudinal investigation of children of depressed and well mothers. [Electronic version]. *Journal of American Academy of Child and Adolescent Psychiatry, 38*(6), 651-659.

Koocher, G.P. (1973). Childhood, death and cognitive development. *Development Psychology, 9*(3), 369-375.

Kosky, R. (1983). Childhood suicidal behaviour. *Journal of Child Psychology and Psychiatry, 24,* 457-468.

Kosky, R., Silburn, S., & Zubrick, S. (1986). Symptomatic depression and suicidal ideation: A comparative study with 628 children. *Journal of Nervous and Mental Disease, 174,* 523-528.

Kubler-Ross, E. (1983). *On children and death.* New York: Macmillan

Langlois, S., & Morrison, P. (2002). Suicide deaths and suicide attempts. *Health Reports, 13*(2), 9-22.

Larzelere, R. E., Anderson, J. J., Jorgensen, D. D., & Ringle, J. L. (2002). *Child suicide risk assessment manual.* Father Flanagan's Boys' Home. Boys Town, NE: Boys Town Press.

Linn, D., & Linn, M. (1978). *Healing life's hurts: Healing memories through the five stages of forgiveness.* New York: Paulist Press.

Livingston, R., & Bracha, S. (1992). Psychotic symptoms and suicidal behaviour in hospitalized children. *American Journal of Psychiatry, 149*(11), 1585-1586.

Marciano, P., & Kazdin, A. (1994). Self-Esteem, depression, hopelessness, and suicidal intent among psychiatrically disturbed inpatient children. *Journal of Clinical Child Psychology, 23*(2), 151-160.

Marr, N., & Field, T. (2001). *Bullycide: Death at playtime.* London: Success Unlimited.

Matter, D. E., & Matter, R. M. (1984). Suicide among elementary school children: A serious concern for counsellors. *Elementary School Guidance and Counselling, 18*(4), 260-267.

McGuire, D., & Ely, M. (1984). Childhood suicide. *Child Welfare, 1,* 10-17.

Michalik-Bonner, D. R. (1990). *An investigation of the relationship between behaviour style, perceptions of family environment, and suicidal ideation in children.* Pennsylvania, IN: University of Pennsylvania.

Mishara, B. (1999). Conceptions of death and suicide in children ages 6-12 and their implications for suicide prevention. *Suicide and Life-Threatening Behaviour, 29*(2), 105-118.

Myers, K. M., Burke, P., & McCauley, E. (1984). Suicidal behaviour by hospitalized preadolescent children on a psychiatric unit. *Journal of the American Academy of Child Psychiatry, 24*(4), 474-480.

Nelson, R., & Crawford, B. (1990). Suicide among elementary school-aged children. *Elementary School Guidance & Counselling, 25,* 123-128.

Normand, C., & Mishara, B. (1992). The development of the concept of suicide in children. *Omega, 25*(3), 183-203.

O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the tower of Babel: A nomenclature for suicidology. *Suicide and Life-Threatening Behaviour, 26*(3), 237-252.

Office of the Surgeon General of the United States. (1999). Children and mental health: Depression and suicide in children. In *Mental health: A report of the Surgeon General.* (1999). Retrieved January 31, 2002, from: http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec5.html

Orbach, I. (1986). The insolvable problem as a determinant in the dynamics of suicidal behaviour in children. *American Journal of Psychotherapy, 60*(4), 511-520.

Orbach, I. (1988). *Children who don't want to live.* San Francisco: Jossey-Bass.

Paulson, M. J., Stone, D., & Sposto, R. (1978). Suicide potential and behaviour in children ages 4 to 12. *Suicide and Life-Threatening Behaviour, 8*(4), 225-242.

Peterson, B. S., Zhang, H., Santa Lucia, R., King, R. A., & Lewis, M. (1996). Risk factors for child psychiatric emergencies identified. *American Academy of Child and Adolescent Psychiatry, 35*(9), 1162-1173.

Pfeffer, C. R. (1979). Clinical observations of play of hospitalized children. *Suicide and Life- Threatening Behaviour, 9*(4), 235-246.

Pfeffer, C. R. (1981). Suicidal behaviour of children. *Exceptional Children, 48,* 170-172.

Pfeffer, C. R. (1984a). Clinical aspects of childhood suicidal behaviour. *Pediatric Annals, 13*(1), 56-57, 60-61.

Pfeffer, C. R. (1984b). Clinical assessment of suicidal behaviour in children. In H. S. Sudak, A. B. Ford, & N. B. Rushford (Eds.), *Suicide in the young* (pp. 171-182). Littleton, MA: John Wright.

Pfeffer, C. R. (1984c). Modalities of treatment for suicidal children: An overview of the literature on current practise. *American Journal of Psychotherapy, 38,* 364-371.

Pfeffer, C. R. (1985). Death preoccupations and suicidal behaviour in children. *Issues in Comprehensive Pediatrics Nursing, 8*(16), 261-278.

Pfeffer, C. R. (1986). *The suicidal child.* New York: Guildford.

Pfeffer, C. R. (1988). Modalities of treatment for suicidal children. In S. Lesse (Ed.), *What we know about suicidal behaviour and how to treat it* (pp. 359-370). Northvale, NJ: Jason Aronson.

Pfeffer, C.R. (1990). Preoccupation with death in "normal" children: The relationship to suicidal behaviour. *Omega, 20*(3), 205-212.

Pfeffer, C. R. (1993). Suicidal children. In A. A. Leenaars (Ed.), *Suicidology: Essays in honour of Edwin S. Shneidman* (pp. 175-185). Northvale, NJ: Jason Aronson.

Pfeffer, C. R. (1997). Childhood suicidal behaviour: A developmental perspective. *The Psychiatric Clinics of North America, 20*(3), 551-562.

Pfeffer, C. R., Hurt, S., Kakuma, T., Perskin, J., Siefker, C., & Nagabhairava, S. (1994). Suicidal children grow up: Suicidal episodes and effects of treatment during follow-up. *Journal of American Academy of Child and Adolescent Psychiatry, 33*(2) 225-230.

Pfeffer, C. R., Hurt, S., Peskin, J., & Siefker, C. (1995). Suicidal children grow up: Ego functions associated with suicide attempts. *American Academy of Child and Adolescent Psychiatry, 34*(10), 1318-1325.

Pfeffer, C. R., Jiang, H., & Kakuma, T. (2000). Child-adolescent suicidal potential index (CASPI): A screen for risk for early onset suicidal behaviour. *Psychological Assessment, 12*(3), 304-318.

Pfeffer, C. R., Klerman, G. L., Hurt, S., Kakuma, T., Peskin, J. R., & Siefker, C. A. (1993). Suicidal children grow up: Rates and psychological risk factors for suicide attempts during follow-up. *Journal of American Academy of Child and Adolescent Psychiatry, 32*(1), 106-113.

Pfeffer, C. R., Normandin, L., & Kakuma, T. (1994). Suicidal children grow up: Suicidal behaviour and psychiatric disorders among relatives. *Journal of American Academy of Child and Adolescent Psychiatry, 33*(8) 1087-1097.

Pfeffer, C. R., Plutchik, R., & Mizruchi, M. (1983). Suicidal and assaultive behaviour in children: Classification, measurement and interrelation. *American Journal of Psychiatry, 140*(2), 154-157.

Rao, U., Weissman, M. M., Martin, J. A., & Hammond, R. W. (1993). Childhood depression and risk of suicide: A preliminary report of a longitudinal study. *Journal of American Academy of Child and Adolescent Psychiatry, 32*(1), 21-27.

Robinson, L. (1984). Outpatient management of the suicidal child. *American Journal of Psychotherapy, 38*(3), 399-412.

Sattem, L. (1990). Suicide prevention in elementary schools. *Death Studies, 14,* 347-370.

Shearer, A. B. (1972). Suicide attempts and depression in children. *Medical Journal of Australia, 2*, 655-657.

Shneidman, E. (1994). *Definition of suicide*. Northvale, NJ: Jason Aronson.

Simpson, G. (Ed.) (1979). *Emile Durkheim, Suicide: A study in sociology*. New York: Free Press.

Sokol, M., & Pfeffer, C. (1992). Suicidal behaviour of children. In Bonger, B. (Ed), *Suicide: Guidelines for assessment, management, and treatment* (pp. 69-83). New York: Oxford University Press.

Statistics Canada. (2002). *Suicides and suicide rates, by sex, by age group.* Retrieved January 18, 2003, from http:www.statcan.ca/English/Pgdb/health01.htm

Stefanowski-Harding, S. (1990). Suicide and the school counsellor. *The School Counsellor, 37,* 328-336.

Stiles, K., & Kottman, T. (1990). Mutual storytelling: An intervention for depressed and suicidal children. *The School Counsellor, 37,* 337-342.

Stillion, J. M., & McDowell, E. E. (1996). *Suicide across the life span.* Washington, DC: Taylor & Francis.

Sturman, S. (1985, February). Stopping child suicide. *Kiwanis Magazine*, 21-23, 45.

Valente, S. (1983). Suicide in school aged children: Theory and assessment. *Pediatric Nursing, 9*(1), 25-29.

White, J. (1994). After the crisis: Facilitating the suicidal student's return to school. *Guidance and Counselling, 10*(1), 10-13.

White, J. (1996). Youth suicide prevention: 'Big picture thinking' for child and youth care professionals. *Journal of Child and Youth Care, 11*(3), 43-51.

White, J. (1998). Comprehensive youth suicide prevention: A model for understanding. In A. Leenaars, S. Wenckstern, I. Sakinofsky, R. Dyck, M. Kral, & R. Bland (Eds.), *Suicide in Canada* (pp. 273-290). Toronto: University of Toronto Press.

Winzer, M. (1994). *Educational psychology in Canadian classrooms* (2nd ed.). Toronto: Prentice-Hall.

Appendix A

Literature Excluded From Analysis

Charles, G., & Matheson, J. (1988). Suicide prevention and intervention in child care programs. *Journal of Child Care, 3,* 39-50.

Cross, T. (1996). Examining claims about gifted children and suicide. *Gifted Child Today, 18*(3), 46-48.

Cross, T., Gust-Brey, K., & Ball, P. (2002). A psychological autopsy of the suicide of an academically gifted student: Researchers' and parents' perspectives. *Gifted Child Quarterly, 45,* 247-264.

Flisher, A. J. (1999). Annotation: Mood disorder in suicidal children and adolescents: Recent developments. *Journal of Child Psychology and Psychiatry, 40*(3), 315-324.

Rao, U., Weissman, M. M., Martin, J. A., & Hammond, R. W. (1993). Childhood depression and risk of suicide: A preliminary report of a longitudinal study. *Journal of American Academy of Child and Adolescent Psychiatry, 32*(1), 21-27.

Stewart, S. E., Manion, I. G., Davidson, S., & Cloutier, P. (2001). Suicidal children and adolescents with first emergency room presentations: Predictors of six-month outcome [Electronic version]. *Journal of American Academy of Child and Adolescent Psychiatry, 40*(5), 580-587.

Walrath, C. M., Mandell, D. S., Qinghong, L., Holden, W., De Carolis, G., Santiago, R. L., & Leaf, P. J. (2001). Suicide attempts in the "Comprehensive Community Mental Health Services for Children and Their Families" program [Electronic

version]. *Journal of American Academy of Child and Adolescent Psychiatry, 40*(1), 1197-1205.

Zahireddin, A. R., & Seghattoleslam, T. (2000). Surveying the personal and psychological aspects of suicide in children referring to Loghman Hakim hospital, 1999-2000. [Electronic version]. *Pejuhandeh, 5*(4), 353-358.

Appendix B

Literature Included in Analysis

Adam, K. S. (1986). Early family influence in suicidal behaviour. *Annals New York Academy of Sciences, 487*, 63-76.

Allan, W., Kashani, J., Dahlmeier, J., Beck, N. Jr., & Reid, J. C. (1998). "Anxious suicidality": A new subtype of childhood suicide ideation? *Suicide and Life-Threatening Behaviour*, *28*(3), 251-260.

Allan, W., Kashani, J., Dahlmeier, J., Tanghizadeh, P., & Reid, J. (1997). Psychometric properties and clinical utility of the scale for suicide ideation with inpatient children. *Journal of Abnormal Child Psychology, 25*(6), 465–473.

Appleby, M. (1994). *Understanding pre-adolescent suicide*. Narellan: Rose Education. Retrieved January 31, 2002, from National Youth Suicide Prevention Strategy Website: http://www.ysp.medeserv.com.au/course.cfm?IngResourcesID=38

Asarnow, J. R. (1992). Suicidal ideation and attempts during middle childhood: Associations with perceived family stress and depression among child psychiatric inpatients. *Journal of Clinical Child Psychology*, *21*(1), 35-40.

Asarnow, J. R., & Carlson, G. (1988). Suicide attempts in preadolescent child psychiatry inpatients. *Suicide and Life-Threatening Behaviour, 18,* 129-136.

Asarnow, J. R., Carlson, G., & Gutherie, D. (1987). Coping strategies, self –perceptions, hopelessness and perceived family environments in depressed and suicidal children. *Journal of Consulting and Clinical Psychology, 55,* 361-366.

Ashworth, J. (2001). *Practice principles: A guide for mental health clinicians working with suicidal children and youth.* Victoria, BC: Ministry of Children and Family Development.

Baartman, H. (1994). Child suicide and harsh punishment in Germany at the turn of the last century. *Paedagogica Historica, 30*(3), 849-864.

Banister, K. (1995). Suicidal children: Assessment and treatment strategies. *Suicide Prevention Newsletter, 8*(4), 1-3, 6.

Barker, P. (1990). *Clinical interviews with children and adolescents.* New York: Norton.

Bauer, A. (1987). The teacher's role with children at risk for suicide. *Educational Horizons, 65*(3), 125-129.

Campbell, N. B., Milling, L., Laughlin, A., & Bush, E. (1993). The psychosocial climate of families with suicidal pre-adolescent children. *American Journal of Orthopsychiatry, 63*(1), 142-145.

Carlson, G. A., Asarnow, J. R., & Orbach, I. (1987). Developmental aspects of suicidal behaviour in children. *Journal of the American Academy of Child and Adolescent Psychiatry, 26,* 186-192.

Carlson, G. A., Asarnow, J. R., & Orbach, I. (1994). Developmental aspects of suicidal behaviour in children and developmentally delayed adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 64,* 93-107.

Celotta, B. (1987). Searching for suicidal precursors in the elementary school child. *American Mental Health Counselors Association Journal, 9*(1), 38-50.

Clark, D. A. (1994). *Exploring the concept of suicide in children through stories: A case study approach.* Florida: Florida State University Press.

Clark, M., Hawley, D., & Tate, L. (1993). Asphyxial deaths due to hanging in children. *Journal of Forensic Sciences*, *38*(2), 344-352.

Cohen-Sandler, R., Berman, A., & King, R. (1982). Life stress and symptomatology: Determinants of suicidal behaviour in children. *Journal of American Academy of Child Psychiatry*, *21*, 178-186.

Corder, B. F., & Haizlip, T. M. (1984). Environmental and personality similarities in case histories of suicide and self-poisoning by children under ten. *Suicide and Life-Threatening Behaviour, 14*(1), 59-66.

Cotton, C. R., & Range, L. (1993). Suicidality, hopelessness, and attitudes toward life and death in children. *Death Studies, 17,* 185-191.

Crook, T., Raskin, A. (1975). Association of childhood parental loss with attempted suicide and depression. *Journal of Consulting and Clinical Psychologists, 43*(2), 227.

Dugan, T. F., & Belfer, M. L. (1989). Suicide in children: Diagnosis, management, and treatment. In D. Jacobs & H. N. Brown (Eds.), *Suicide: Understanding and responding* (pp. 201-220). Madison, CT: International Universities Press.

Dyck, R. J., Mishara, B. L., & White, J. (1998). *Suicide in children, adolescents and seniors: Key findings and policy implications*. Ottawa. National Forum on Health, Health Canada.

Eth, S., Pynoos, R. S. & Carlson, G. A. (1984). An unusual case of self-inflicted death in childhood. *Suicide and Life-Threatening Behaviour, 14*, 157-165.

Fish, W. C., & Waldhart-Letzel, E. (1981). Suicide and children. *Death Education*, *5*(3), 215-222.

Fitzgerald, H. (1992). *The grieving child.* Toronto: Simon & Schuster.

Fremouw, W. J., Perczel, M., & Ellis, T. E. (1990). *Suicide risk assessment and response guidelines.* New York: Pergamon.

Ginn, P. D., Range, L. M., & Hailey, B. J. (1988). Community attitudes toward childhood suicide and attempted suicide. *Journal of Community Psychology, 16,* 144-151.

Glaser, K. (1971). Suicidal children: Management. *American Journal of Psychotherapy, 25,* 27-36.

Goldston, D. B. (2000). *Assessment of suicidal behaviours and risk among children and adolescents.* Wake Forest University School of Medicine, National Institute for Mental Health.

Greene, D. B. (1994). Childhood suicide and myths surrounding it. *Social Work, 39,* 230-232.

Guetzloe, E. C. (1988). Suicide and depression: Special education's responsibility. *Teaching Exceptional Children, 20*(4), 24-28.

Guetzloe, E. C. (1991). Suicide and the exceptional child. [Electronic version]. *ERIC Digest.* Retrieved January 26, 2003, from ERIC Digest database, from http:www.ericfacility.net/ericdigests/ed340152.html

Herring, R. (1990). Suicide in the middle school: Who said kids will not? *Elementary School Guidance and Counselling, 25,* 129-137.

Horowitz, L. M., Wang, P. S., Koocher, G. P., Burr, B. H., Smith, M. F., Klavon, S., & Cleary, P. D. (2001). Detecting suicide risk in a pediatric emergency department: Development of a brief screening tool [Electronic version]. *Pediatrics, 107*(5), 1133-1138.

Joffe, R. T., & Offord, D. R. (1983). Suicidal behaviour in childhood. *Canadian Journal of Psychiatry, 28,* 57-63.

Juhnke, G. A. (1996). The adapted SAD PERSONS: A suicide assessment scale designed for use with children. *Elementary School Guidance & Counseling, 30*(4), 252-258.

Kestenbaum, J. (1992). *Suicidal versus non-suicidal children: Psychological, cognitive, psychiatric and family history differences.* California: California School of Professional Psychology.

Klimes-Dougan, B., Free, D., Ronsaville, D., Stilwell, J., Welsh, J., & Radke-Yarrow, M. (1999). Suicidal ideation and attempts: A longitudinal investigation of children of depressed and well mothers. [Electronic version]. *Journal of American Academy of Child and Adolescent Psychiatry, 38*(6), 651-659.

Kosky, R. (1983). Childhood suicidal behaviour. *Journal of Child Psychology and Psychiatry, 24,* 457-468.

Kosky, R., Silburn, S., & Zubrick, S. (1986). Symptomatic depression and suicidal ideation: A comparative study with 628 children. *Journal of Nervous and Mental Disease, 174,* 523-528.

Larsson, B., & Melin, L. (1992). Prevalence and short-term stability of depression symptoms in schoolchildren. *Acta Psychiatrica Scandinaviva, 85*(1), 17-22.

Livingston, R., & Bracha, S. (1992). Psychotic symptoms and suicidal behaviour in hospitalized children. *American Journal of Psychiatry, 149*(11), 1585-1586.

Marciano, P., & Kazdin, A. (1994). Self-esteem, depression, hopelessness, and suicidal intent among psychiatrically disturbed inpatient children. *Journal of Clinical Child Psychology*, *23*(2), 151-160.

Marr, N., & Field, T. (2001). *Bullycide: Death at playtime.* London: Success Unlimited.

Matter, D. E., & Matter, R. M. (1984). Suicide among elementary school children: A serious concern for counsellors. *Elementary School Guidance and Counselling*, *18*(4), 260-267.

McGuire, D., & Ely, M. (1984). Childhood suicide. *Child Welfare, 1,* 10-17.

Michalik-Bonner, D. R. (1990). *An investigation of the relationship between behaviour style, perceptions of family environment, and suicidal ideation in children.* Pennsylvania, IN: University of Pennsylvania.

Miles, M. S., & Demi, A. S. (1992). A comparison of guilt in bereaved parents whose children died by suicide, accident, or chronic disease. *Omega, 24*(3), 203-215.

Milling, L., Campbell, N., Bush, N., & Laughlin, A. (1994). The relationship of suicidality and psychiatric diagnosis in hospitalized pre-adolescent children. *Child Psychiatry and Human Development*, *23*(1), 225-229.

Mishara, B. (1999). Conceptions of death and suicide in children ages 6-12 and their implications for suicide prevention. *Suicide and Life-Threatening Behaviour*, *29*(2), 105-118.

Myers, K. M., Burke, P., & McCauley, E. (1984). Suicidal behaviour by hospitalized preadolescent children on a psychiatric unit. *Journal of the American Academy of Child Psychiatry*, *24*(4), 474-480.

Nelson, R., & Crawford, B. (1990). Suicide among elementary school-aged children. *Elementary School Guidance & Counselling, 25,* 123-128.

Normand, C., & Mishara, B. (1992). The development of the concept of suicide in children. *Omega, 25*(3), 183-203.

Office of the Surgeon General of the United States. (1999). Children and mental health: Depression and suicide in children. In *Mental health: A report of the Surgeon General.* (1999). Retrieved January 31, 2002, from: http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec5.html

Orbach, I. (1984). Personality characteristics, life circumstances and dynamics of suicidal children. *Death Education, 8,* 37-52.

Orbach, I. (1986). The insolvable problem as a determinant in the dynamics of suicidal behaviour in children. *American Journal of Psychotherapy, 60*(4), 511-520.

Orbach, I. (1988). *Children who don't want to live.* San Francisco: Jossey-Bass.

Orbach, I., Feshbach, S., Carlson, G., Blaubman, G., & Gross, Y. (1983). Attraction and repulsion by life and death in suicidal and in normal children. *Journal of Consulting and Clinical Psychology, 51,* 661–670.

Orbach, I., Feshbach, S., Carlson, G., & Ellenberg, L. (1984). Attitudes toward life and death in suicidal, normal and chronically ill children: An extended replication. *Journal of Consulting and Clinical Psychology, 52*(6), 1020-1027.

Orbach, I., & Glaubman, H. (1978). Suicidal, aggressive and normal children's perception of personal and impersonal death. *Journal of Clinical Psychology, 34*(4), 850-857.

Orbach, I., & Glaubman, H. (1979). The concept of death and suicidal behaviour in young children. *Journal of the American Academy and Child Psychiatry, 18*(4), 668-678.

Paulson, M. J., Stone, D., & Sposto, R. (1978). Suicide potential and behaviour in children ages 4 to 12. *Suicide and Life-Threatening Behaviour, 8*(4), 225-242.

Peterson, B. S., Zhang, H., Santa Lucia, R., King, R. A., & Lewis, M. (1996). Risk factors for child psychiatric emergencies identified. *American Academy of Child and Adolescent Psychiatry, 35(*9), 1162-1173.

Pfeffer, C. R. (1979). Clinical observations of play of hospitalized children. *Suicide and Life- Threatening Behaviour, 9*(4), 235-246.

Pfeffer, C. R. (1981). Suicidal behaviour of children. *Exceptional Children, 48,* 170-172.

Pfeffer, C. R. (1981). Suicidal behaviour of children: Review with implications for research and practise. *American Journal of Psychiatry, 138*(2), 154-159.

Pfeffer, C. R. (1982). Intervention for suicidal children and their parents. *Suicide and Life-Threatening Behaviour, 12*(4), 240-248.

Pfeffer, C. R. (1984). Clinical aspects of childhood suicidal behaviour. *Pediatric Annals, 13*(1), 56-57, 60-61.

Pfeffer, C. R. (1984). Clinical assessment of suicidal behaviour in children. In H. S. Sudak et al. (Eds.). *Suicide in the young* (pp. 171-182). Littleton, MA: John Wright.

Pfeffer, C. R. (1984). Modalities of treatment for suicidal children: An overview of the literature on current practise. *American Journal of Psychotherapy, 38,* 364-371.

Pfeffer, C. R. (1985). Death preoccupations and suicidal behaviour in children. *Issues in Comprehensive Pediatrics Nursing*, *8*(1-6), 261-278.

Pfeffer, C. R. (1985). *Strategies for treatment of suicidal children*. National Conference on Youth Suicide, Washington, DC.

Pfeffer, C. R. (1985). Suicidal fantasies in normal children. *The Journal of Nervous and Mental Disease, 173*(2), 78-83.

Pfeffer, C. R. (1986). *The suicidal child.* New York: Guildford.

Pfeffer, C. R. (1989). Assessment of suicidal children and adolescents. *The Psychiatric Clinics of North America, 12*(4), 861-872.

Pfeffer, C. R. (1989). Studies of suicidal preadolescent and adolescent inpatients: A critique of research methods. *Suicide and Life-Threatening* Behaviour, 19, 58-77.

Pfeffer, C.R. (1990). Preoccupation with death in "normal" children: The relationship to suicidal behaviour. *Omega, 20*(3), 205-212.

Pfeffer, C. R. (1993). Suicidal children. In A. A. Leenaars (Ed.), *Suicidology: Essays in honour of Edwin S. Shneidman* (pp. 175-185). Northvale, NJ: Jason Aronson.

Pfeffer, C. R. (1997). Childhood suicidal behaviour: A developmental perspective. *The Psychiatric Clinics of North America, 20*(3), 551-562.

Pfeffer, C. R., Hurt, S., Kakuma, T., Perskin, J., Siefker, C., & Nagabhairava, S. (1994). Suicidal Children grow up: Suicidal Episodes and effects of treatment during follow-up. *Journal of American Academy of Child and Adolescent Psychiatry, 33*(2), 225-230.

Pfeffer, C. R., Hurt, S., Peskin, J., & Siefker, C. (1995). Suicidal children grow up: Ego functions associated with suicide attempts. *American Academy of Child and Adolescent Psychiatry, 34*(10), 1318-1325.

Pfeffer, C. R., Klerman, G. L., Hurt, S., Kakuma, T., Peskin, J. R., & Siefker, C. A. (1993). Suicidal children grow up: Rates and psychological risk factors for suicide attempts during follow-up. *Journal of American Academy of Child and Adolescent Psychiatry, 32*(1), 106-113.

Pfeffer, C. R., Normandin, L., & Kakuma, T. (1994). Suicidal children grow up: Suicidal behaviour and psychiatric disorders among relatives. *Journal of American Academy of Child and Adolescent Psychiatry, 33*(8) 1087-1097.

Pfeffer, C. R., Plutchik, R., & Mizruchi, M. (1983). Suicidal and assaultive behaviour in children: Classification, measurement and interrelation. *American Journal of Psychiatry, 140*(2), 154-157.

Pfeffer, C. R., Zuckerman, S., Plutchik, R., & Mizruchi, M. (1984). Suicidal behaviour in normal school children: A comparison with child psychiatric inpatients. *Journal of American Academy of Child and Adolescent Psychiatry, 23*(4), 416-423.

Powers, D. (1987). Howie's ordeal: Crisis management and planning in advance for potentially suicidal children. *Residential Treatment for Children and Youth, 5*(1), 3-16.

Robinson, L. (1984). Outpatient management of the suicidal child. *American Journal of Psychotherapy, 38*(3), 399-412.

Rosenthal, P. A., & Rosenthal, S. (1984). Suicidal behaviour by preschool children. *American Journal of Psychiatry, 141*(4), 520-525.

Rosof, B. D. (1994). *The worst loss: How families heal from the death of a child.* New York: Henry Holt.

Rudestam, K. E., & Imbroll, D. (1983). Societal reaction to a child's death by suicide. *Journal of Consulting and Clinical Psychology, 51*(3), 461-462.

Safran, S. p., & Lehman, C. J. (1987). Suicidal behaviour in preadolescent children: A growing concern. *BC Journal of Special Education, 11*(1), 17-22.

Sattem, L. (1990). Suicide prevention in elementary schools. *Death Studies, 14,* 347-370.

Schuyler, D. (1973). When was the last time you took a suicidal child to lunch? *Journal of School Health, 43*(8), 504-506.

Shamoo, T.K., & Patros, P.G. (1990). *Helping your child cope with depression and suicidal thoughts.* San Francisco: Jossey-Bass.

Shearer, A. B. (1972, September). Suicide attempts and depression in children. *Medical Journal of Australia, 2,* 655-657.

Sokol, M., & Pfeffer, C. (1992). Suicidal behaviour of children. In Bonger, B. (Ed), *Suicide: Guidelines for assessment, management, and treatment* (pp. 69-83). New York: Oxford University Press.

Stefanowski-Harding, S. (1990). Suicide and the school counsellor. *The School Counsellor, 37,* 328-336.

Stiles, K., & Kottman, T. (1990). Mutual storytelling: An intervention for depressed and suicidal children. *The School Counsellor, 37,* 337-342.

Stillion, J. M., & McDowell, E. E. (1996). *Suicide across the life span.* Washington, DC: Taylor & Francis.

Sturman, S. (1985, February). Stopping child suicide. *Kiwanis Magazine*, 21-23, 45.

Valente, S. (1983). Suicide in school aged children: Theory and assessment. *Pediatric Nursing, 9*(1), 25-29.

Wise, A. J., & Spengler, P. M. (1997). Suicide in children younger than age fourteen: Clinical judgement and assessment issues. *Journal of Mental Health Counseling, 19*(4), 18-35.

Workman, C. G., & Prior, M. (1997). Depression and suicide in young children. *Issues in Comprehensive Pediatric Nursing, 20,* 125–132.

Wozencraft, T., Wagner, W., & Pellegrin, A. (1991). Depression and suicidal ideation in sexually abused children. *Child Abuse and Neglect: The International Journal, 15*(4), 505-511.

Appendix C

Qualifying Childhood Suicidality: A Professional's Guide

DETERMINING THE PREVALENCE OF RISK FACTORS CONCERNING SUICIDAL CHILDREN (PERSONS AGED 5 TO 12 YEARS OF AGE)

Date of Interview:

Name of Child:

Name(s) of Caregivers:

This Form summarizes the responses of the Child: yes ___ no ___

This Form summarizes the responses of the Caregivers: yes ___ no ___

Assessment completed by:

SECTION ONE: ASSESSMENT OF RISK FACTORS

Note: For each risk factor, please review the Definition Key in Section Two for examples and areas needing exploration.

1. Family Discord and Violence:
   Comments: [actual form allows more space for comments throughout]
2. Depressive Symptoms:
   Comments:
3. Significant Loss:
   Comments:
4. Poor and/or Dysfunctional Parent-Child Communication and Bonding:
   Comments:
5. Aggressive Behaviour:
   Comments:
6. Stress:
   Comments:
7. Physical Abuse:
   Comments:
8. Parental Separation and/or Divorce:
   Comments:

9. Hopelessness:

   Comments:

10. Academic Difficulties:

    Comments:

11. Prior Suicidal Behaviours:

    Comments:

12. Death Understanding:

    Comments:

Overall Determination of the Current Suicide Risk Level of Child:

Comments: (short term/long term risk; conditions which may activate an increase in risk)

Plan for Intervention:

Next Appointment:

SECTION TWO: DEFINITION KEY

1. Family Discord and Violence

Definition:

Family discord is comprised of many aspects and incorporated with the dysfunctional interactions between family members, particularly the parents, who ideally ought to represent stability and safety to children. Family discord includes daily conflict, hostility or arguing, ambivalence, rejection, alcohol or drug abuse, physical or sexual abuse, parental psychiatric disorder and parental suicidal behaviour (Pfeffer, Klerman, Hurt, Kakuma, Peskin, & Siefker, 1993, pp. 106-107).

Characteristics Present: (list is not exhaustive)

Daily conflict & hostility:	Yes ___	No ___	Need further exploration ___
Ambivalence:	Yes ___	No ___	Need further exploration ___
Parental rejection of child:	Yes ___	No ___	Need further exploration ___
Alcohol or drug abuse by caregivers:	Yes ___	No ___	Need further exploration ___
Psychiatric diagnoses (of child, parent/s, diagnosed when, by whom, medications, present status, outcomes)	Yes ___	No ___	Need further exploration ___

2. Depressive Symptoms:

Definition: the main feature is either a depressed mood or loss of interest in nearly all activities and associated symptoms of which some are changes in eating and sleeping patterns, reduction in concentration, poor affective responses and/or significant mood swings, difficulty in thinking or concentrating, decreased energy, irritation (Fremouw & Perczel, 1990, p. 66).

Characteristics Present: (list is not exhaustive)

Change in eating pattern:	Yes __	No ___	Need further exploration ____
Change in sleeping pattern:	Yes __	No ___	Need further exploration ____
Frequent mood swings:	Yes __	No ___	Need further exploration ____
Excessive crying:	Yes __	No ___	Need further exploration ____
Hitting self or others:	Yes __	No ___	Need further exploration ____
Withdrawing from family and friends	Yes __	No ___	Need further exploration ____

3. Significant Loss:

Definition: any event resulting in the child no longer having access to or restricted access to someone/something he/she perceived as supportive and loving (Stiles & Kottman, 1990, p. 337)

Characteristics Present: (list is not exhaustive)

Death of a parent:	Yes __	No ___	Need further exploration ____
Death of a significant other, e.g. sibling, pet:	Yes __	No ___	Need further exploration ____
Removal of child from biological home:	Yes __	No ___	Need further exploration ____
Loss of a relationship:	Yes __	No ___	Need further exploration ____
Restrictive access to someone/something child perceives as supportive and loving:	Yes __	No ___	Need further exploration ____

4. Poor and/or Dysfunctional Parent-Child Communication and Bonding:

Definition: child is treated as an adult with adult responsibilities beyond the child's maturational and skill level; role of spouse replacement, verbal persecution, hostility and child abuse, emotional stress experienced by the child, lack of emotional support from parents (Glaser, 1971, p. 30)

Characteristics Present: (list is not exhaustive)

Child has inordinate responsibility for parent:	Yes ___	No ___	Need further exploration ___
Low tolerance for frustration:	Yes ___	No ___	Need further exploration ___
Intense dependency of parent on child:	Yes ___	No ___	Need further exploration ___
Projection of inappropriate parental feelings on child:	Yes ___	No ___	Need further exploration ___
Symbiotic parent-child interaction:	Yes ___	No ___	Need further exploration ___

5. Aggressive Behaviour (by the child):

Definition: the expression of the anger towards others (such as bullying) or towards himself/herself (repeated "accidents" or suicide attempts); the child's mood swings from depression (anger turned inward) to violence against others (anger turned outwards); explore evidence of assaultive or suicidal behaviour of the parents (Pfeffer, Plutchik, Mizruchi, 1983, p. 154).

Characteristics Present: (list is not exhaustive)

Bullying in school:	Yes ___	No ___	Need further exploration ___
Hitting siblings:	Yes ___	No ___	Need further exploration ___
Parental assaultive behaviour:	Yes ___	No ___	Need further exploration ___
Aggressive expression of emotions:	Yes ___	No ___	Need further exploration ___
Lack of anxiety:	Yes ___	No ___	Need further exploration ___

6. Stress:

Definition: (change or uncertainty in the environment produces stress; more changes creates more stress) (Cohen-Sandler, Berman, & King, 1982, pp. 182-183)

Characteristics Present: (list is not exhaustive)

Birth of a sibling:	Yes __	No ___	Need further exploration ____
Death of a grandparent:	Yes __	No ___	Need further exploration ____
Hospitalization of parent:	Yes __	No ___	Need further exploration ____
Divorce of parents:	Yes __	No ___	Need further exploration ____
Broken home:	Yes __	No ___	Need further exploration ____
Peer rejection:			

7. Physical Abuse:

Definition: A deliberate, non-accidental physical assault or action by an adult or significantly older or more powerful child that results or is likely to result in physical harm to a child. It includes the use of unreasonable force to discipline a child or to prevent a child from harming him/herself or others. The injuries sustained by the child may vary in severity and range from minor bruising, burns, welts or bite marks to major fractures of the bones or skull, and, in its most extreme form, the death of a child. Physical assault is a crime. (BC Ministry of Children and Families, 1998, p. 3)

Characteristics Present: (list is not exhaustive)

Unexplained bruising, burns, welts or bite marks:	Yes __	No ___	Need further exploration ____
Intense feelings of fear directed at a parent or school peer	Yes __	No ___	Need further exploration ____
Fear or intense feelings of uncomfortable exposure of body:	Yes __	No ___	Need further exploration ____
Lack of proper parental expressions of anger:	Yes __	No ___	Need further exploration ____

8. Parental Separation and/or Divorce:

Definition: examine the level and severity of conflict between the parents; examine the impact of the parental conflict on the coping of the children (Paulson, Stone, & Sposto, 1978, p. 237)

Characteristics Present: (list is not exhaustive)

Conflict between parents:	Yes ___	No ___	Need further exploration ____
Refusal of one parent to allow child to see other:	Yes ___	No ___	Need further exploration ____
Parental rejection of child:	Yes ___	No ___	Need further exploration ____
Custodial parent treats child like a spouse:	Yes ___	No ___	Need further exploration ____

9. Hopelessness:

Definition: Hopelessness involves the perception that current difficult circumstances will be maintained with little likelihood of a change for the better. This perception may lead to pressures on self-esteem regulation and promotion of poor self-concepts, notably low appraisal of one's social competence and intensification of feelings of shame and guilt (Pfeffer, 1997, p. 554).

Characteristics Present: (list is not exhaustive)

Poor self-esteem:	Yes ___	No ___	Need further exploration ____
Intense feelings of shame:	Yes ___	No ___	Need further exploration ____
Intense feelings of guilt:	Yes ___	No ___	Need further exploration ____
Low confidence in social settings:	Yes ___	No ___	Need further exploration ____

10. Academic Difficulties:

Definition: (school environment: poorly funded school versus an affluent school, culturally sensitive versus a judgmental school, identify one supportive teacher; a child was not doing well academically what issue(s) is not being addressed: inability to hear (partial deafness) or see the instructions from a teacher (near sighted vision), an undiagnosed learning disability (for example dyslexia), lack of concentration due to fear of being bullied, or family violence at home, a parent's erratic behaviour due to mental illness, an undiagnosed mental illness/disorder of the child (for example attention deficit disorder, depression), hunger (if a child is hungry he/she cannot concentrate on learning) Nelson & Crawford, 1990, p. 125).

Characteristics Present: (list is not exhaustive)

Academic failure:	Yes ___	No ___	Need further exploration ____
Learning disabilities:	Yes ___	No ___	Need further exploration ____
Latchkey child:	Yes ___	No ___	Need further exploration ____
Student illness/disability:	Yes ___	No ___	Need further exploration ____

11. Prior Suicidal Behaviours:

Definition: "A potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence (either explicit or implicit) that the injury was self-inflicted and that the person intended at some (nonzero) level to kill himself/herself. A suicide attempt may or may not result in injuries" (O'Carroll et al., 1996, p. 247).

Characteristics Present: (list is not exhaustive)

Thoughts of suicide: (how often? when?)	Yes ___	No ___	Need further exploration ____
Prior attempts: (when? how?)	Yes ___	No ___	Need further exploration ____
Any suspicious accidents:	Yes ___	No ___	Need further exploration ____
Suicidal parent:	Yes ___	No ___	Need further exploration ____
Suicide in family:	Yes ___	No ___	Need further exploration ____

12. Death Understanding:

Definition: if death is considered temporary or pleasant, a child may be more inclined to take suicidal action; remember, death understanding and preoccupations in children fluctuate and are affected by the child's state of mind; if the child is under great stress, he/she is often seen regressing in his/her cognitive understanding of the finality of death to the point where he/she may begin to view death as reversible and thus become higher risk for suicidal behaviour (Pfeffer, 1984, p. 172).

Characteristics Present: (list is not exhaustive)

Death is permanent:	Yes __	No ___	Need further exploration ____
Child experiencing severe stress:	Yes __	No ___	Need further exploration ____
Death is temporary:	Yes __	No ___	Need further exploration ____
Death is pleasant:	Yes __	No ___	Need further exploration ____