Suicide and Depression in Children Within the Ages of Five to Twelve Years: A Review

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SUICIDE AND DEPRESSION IN CHILDREN
WITHIN THE AGES OF FIVE TO TWELVE YEARS: A REVIEW

BY

ESTHER R. MUNIZZI
B. A., Florida Technological University, 1974

SPECIALTY PAPER

Submitted in partial fulfillment of the requirements for the degree of Master of Science: Psychology in the Graduate Studies Program of the College of Social Sciences of Florida Technological University

Orlando, Florida
1977
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Introduction

The subject of suicide and depression in children is currently gaining more emphasis in the literature with regard to both the theoretical and research-oriented aspects. Yet, these areas have by no means been exhausted, as a great body of information and knowledge is still developing. The problem, in retrospect, is that the topic of suicide and depression has been more thoroughly investigated in terms of adult psychiatry, while somewhat overlooked in terms of child psychiatry (Ackerly, 1967; Anthony, 1975; Bakwin and Bakwin, 1969; Kanner, 1972; Toolan, 1962; Schrut, 1964).

It is the intention of this paper to pursue suicide and depression with relevance to children, by evaluating both the earlier and the more contemporary literature. Hopefully, a greater awareness will be created, and perhaps a message of urgency regarding this form of crisis will be communicated.

Consequently, this manuscript consists of a review of the pertinent literature of children between the ages of five and twelve (school age through preadolescence) regarding depression, suicide, and what the relationship between suicide and depression is, respectively. In addition, the question of whether or not it is possible to predict the occurrence of suicide in the depressed child will be considered.
Prevalence of Depression in Children

That the topic of depression in children is becoming a greater focus of concern was described by Anthony (1975) in the following statement:

Childhood depression is still . . . an undeveloped field on the way to becoming scientifically conceived but still in a proto-scientific state. A multitude of ideas are scattered throughout it none of which has yet quite got "off the ground." There is not much consensus about "findings" and formulations still have to be constructed from the beginning. We are still at the stage of "problem solving" rather than "puzzle solving." But interest in the field is great, and there is evidence of maturation. Our prediction is that the diagnosis of clinical depression of childhood will be made with increasing frequency in the future. (p. 273)

Some of the earlier studies regarding depression in infants and younger children are essential to the understanding of child psychoneuroses. Klein, who was cited by Anthony (1975), discovered in infants what was termed the "depressive position." Here, the child will develop a tendency towards depression in later life if he does not master what is referred to by Klein as "core" or "crucial" experiences of development (cited by Anthony, 1975). These experiences are described by Klein as: the frustrating alimentary experience; the use of introjection-projection mechanisms; and the conflict based on ambivalence (cited by Anthony, 1975).
Harrison and McDermott (1972), and Renshaw (1974), cited the work of Bowlby, who discovered that infants between the ages of 15 and 30 months developed separation-anxiety when kept apart from their mothers. When a prolonged absence from maternal presence occurred, three stages of behavior were noted in these children. First, there was an initial reaction of anxiety, active protest, and crying. Second, the child became overwhelmed by despair and depression accompanied by withdrawal, intermittent crying, and an increase in feelings of sadness and hopelessness; the third stage was characterized by detachment between the child and his environment. Here, he reacted to his environment with an unemotional, distant and almost mechanical-like attitude.

Spitz and Wolf (1945) investigated the genesis of psychiatric conditions in infancy and early childhood in terms of anaclitic depression. Infants since fourteen days old were separated from their mothers for a period of six or eight months and were either hospitalized or reared in a nursery. Spitz and Wolf reported the following clinical signs of depression in these infants: weeping, withdrawal, retardation of movement, sadness, rigidity of expression and hyper-irritability.

Further evidences that confirm the existence of a depressive reaction in infants and younger children have been demonstrated by Bibring (1953), Engel (1962), Fenichel (1951), and Freud (1917). Rie (1966), however, opposed the notion of depression in children. He claimed that the symptoms of adult non-psychotic depression are "virtually non-existent in childhood" (p. 653), and almost discards
the entity completely. That depression in children may be manifested in different ways as compared to adults by such behaviors as eating disturbances or hyperactivity, has also been suggested by the Group for the Advancement of Psychiatry (1974). If there is some precipitating factor such as a loss of a love object, typically the onset of depression will appear more acute (Group for the Advancement of Psychiatry, 1974). Those symptoms included in this syndrome are ambivalence toward the loved object, sadness, loss of self-esteem, self-depreciation, and sometimes psycho-motor retardation (Group for the Advancement of Psychiatry, 1974).

Glaser (1967) contended that while depression is a more clearly defined and known condition in adults, such is not the case with children. Actually, the symptoms do not appear to be as easily recognizable, or may be masked by other symptoms (Glaser, 1967; Poznanski and Zrull, 1970; Toolan, 1962). Mosse (1974) supported the position that many studies of depression ought to be more distinctive in terms of adult or child psychiatry. Mosse contended that the differences between childhood and adult depression could be understood in terms of variations between intensity, severity, and duration of symptoms.

The question of the prevalence of depression in children is posed in this statement made by Gore (1976):

The frequency of true depression in early and middle childhood is a question about which child psychiatrists find it hard to agree. Some say it's rare and that only in late childhood and adolescence does depression begin to appear. Others point to feeding disorders, withdrawal, prolonged "mourning-type" reactions and learning blocks as an expression of depression. (p. 111)
Poznanski and Zrull (1970) concurred that affective depression is seen clinically in children, but many authors do not accept this. There are reasons why discrepancies exist: first of all, it is rare for children under five to be diagnosed as clinically depressed because of the lack of clarity in definition as to what is or is not a symptom; second, dynamically, psychic tension might find a way of release in children this young because of their activeness and hence not be "pent up"; and third, young children can become depressed as a result of physical neglect or mistreatment, which is hard to ascertain because of the scarcity of records (Poznanski and Zrull, 1970).

Boulanger (1966) emphasized that although the subject of depression before the age of twelve has been a common topic of controversy, more and more clinicians are recognizing its existence. Actually, Boulanger felt that the difficulty lies in applying a well structured diagnosis to the child who is changing and developing so rapidly.

In a recent article entitled: "Suicide Rate Among Young School Children Grows," Saltzman supported the position that depression does indeed occur clinically in children (Sentinel Star, December 11, 1976, p. 3). Saltzman stated that in children, depression is usually manifested by such symptoms as hyperactivity, hypochondria, poor academic and social adjustment, delinquency, physical aggression, and stealing.

Toolan (1962) held the opinion that the concept that children do not experience depression is erroneous. He reported the signs and symptoms of childhood depression to differ from those of adult depressive reactions, but the existence of this clinical entity in children
could not be ignored. Such symptoms are often behaviorally manifested in the latency child who may throw temper tantrums, become truant, disobedient, masochistic, self-destructive, or run away from home (Toolan, 1962).

Further support that depression in children is common has been provided by Cytryn and McKnew (1972). These authors believed that the major difference between adult and childhood depression is that children do not remain in this affective state as long as do many adults. Cytryn and McKnew stated that the more common or "acute" form of depression in children does not appear to have a gross effect in impairing the child's daily functioning, thought processes, or physical health. The longer lasting or "chronic" form of this syndrome is viewed by these authors in terms of depressive illness rather than depressive affect. In the "chronic" form, there is a greater impairment in the child's overall daily functioning which affects those areas of social, emotional, and academic adjustment (Cytryn and McKnew, 1972). Further, physiological disturbances are frequently evidenced in depressed children by such difficulties in sleeping and eating (Cytryn and McKnew, 1972). There is a third type of depression reflected in the research of Cytryn and McKnew -- that which is not readily identifiable, but rather masked. This form appears to contain a more pervasive quality and lacks a clear-cut symptom (Cytryn and McKnew, 1972). For example, some of the behaviors which might be manifested are hyperactivity, hypochondriasis, aggressiveness, and exaggerated extroversion behavior (Cytryn and McKnew, 1972).
Statten (1961) viewed the subject of depression in children to be one of controversy. The difficulty, according to Statten, is in comprehending the depressive syndrome in terms of child psychiatry. While Statten claimed that there is continued ambiguity in the diagnosis of depression in children, he argued that the emphasis in the literature has been greater in terms of adult psychiatry.

Symonds (1966) was also in agreement that much of the comprehensive literature in child psychiatry has failed to make available extensive information on the topic of childhood depression. He contended that there is an inaccurate representation of actual clinical evidences of this syndrome, when in fact more and more child psychiatrists are making this diagnosis with increasing frequency.

Another researcher who has noted the oversight in the literature concerning childhood depression is Malmquist (1971). Malmquist, who has also held the position that the controversy of childhood depression continues, provided some of the following reasons for this contention. First, there is difficulty in coming to an agreement on the term "depression" (e.g., is it: an internal affective state, a set of physiologic responses, a clinical syndrome, or a nosological entity such as an illness?). Secondly, the question is presented whether depression is a single illness with various signs and symptoms -- or in fact a combination of several types of illnesses. Thirdly, the problem of diagnosis of depression depends on whether or not the physician is in private practice, the setting in which the patient is evaluated (e.g., hospitals or clinics); the theoretical approach
of the psychiatrist; and the socio-economic class of the patient.

Sandler and Joffe (1965) emphasized that there has been too little unanimity on the topic of childhood depression as a clinical entity. The consensus between these two authors is that the literature has been deplete of agreed behavioral, descriptive, and psychodynamic criteria. Moreso, there have been indications of depression in children described as "depressive equivalents" in the form of eating or sleeping disturbances, restlessness, boredom, psychosomatic symptoms and other disguiseable behaviors (Sandler and Joffe, 1965).

Anthony (1975) opposed the belief that depressive manifestations in children are extraordinary. In fact, he contended that there is little doubt among those who observe transient depressions and moods seen in adults, to be similar to those that occur in childhood.

Glennie, during a symposium on childhood depression at Cambridge University in 1959, was reported by Symonds (1966) as stating:

I think depression in children occurs quite frequently in the illnesses of children, though it is hard to find straight-forward evidence of the single symptom of depression. The picture in children is usually less clear-cut, anxiety seems to play a more important part. (p. 189)

Anthony (1975) cited Zetzel, who believed that the confusion on the subject of depression in children stems from the failure to distinguish depression either as a basic affective experience that is significant psychologically, or as an illness in which there is a definite regressive syndrome.

Further support that children experience depressive symptomology was provided by Lippman, as cited by Symonds (1966). Lippman
purported that children do suffer from neurotic depression more often than is reported in the literature (cited by Symonds, 1966). One of the reasons that depression is typically overlooked in children, according to Lippman, is because unlike the adult, the depressed child is still able to function on an active level and maintain an interest in his environment (cited by Symonds, 1966).

Rie (1966) cited Sperling, who maintained the belief that depression is rare in children. Sperling's assumption was that depressive moods and wishes to destroy oneself are foreign to the nature of the child (cited by Rie, 1966). Hence, depression in the child is not easily recognizable, according to Sperling, since there is a difference between adult and child behavioral manifestations (cited by Rie, 1966).

Hamberger, according to Symonds (1966), questioned the ability of the child to express such a complicated affect as depression and stated: "The child naturally lacks the capacity to analyze his emotions and the child does not know how to express his emotions verbally" (p. 190).

Rie (1966) reported on Mahler, who held the position that a state of depression observed in the adult is not likely to be seen in the infant or older child because of the immaturity of personality structure.

Rochlin (1965) questioned the existence of depression in children on the basis of the implicated psychodynamics. According to Rochlin, depression is a superego phenomenon involving aggression directed against the self with a certain intensity and duration. He
goes on to say that this phenomenon is not yet present in the child; therefore the existence of a clinical depression in children is unlikely.

One of the reasons why depression in children is so frequently questioned according to Munro (1969) is because this psychiatric syndrome has not had extensive research with controlled data which make possible such absolute conclusions.

It appears then, that although the subject of depression in children continues to be one of debate and controversy, evidence in the literature indicates that a greater awareness is being aroused among investigators. The complexity of the syndrome is one of the major aspects being researched. Anthony (1975) contended that the complexity of the subject of depression in children and its interrelation between such factors as developmental changes, representation and language, logical processes, etc., are all essential, integral parts of the syndrome: "The question whether depression does or does not occur during childhood, therefore, can no longer stand by itself" (p. 235). The complexity of childhood depression mentioned by Anthony may be further understood in terms of descriptive and theoretical evidence. The subsequent sections will present such evidence as interpreted by the Psychodynamic, Behavioral, and Phenomenological approaches, respectively.

Descriptions and Theories of Depression in Children

**Psychodynamic formulations.** Schecter (1957) stated that when children experience or feel the threat of loss of a love object such as a mother or father, they develop feelings of frustration, rage,
helplessness, and worthlessness. It is his belief that these feelings result in what is referred to as depression.

Gould (1965) hypothesized that depression is a common state in children which is often overlooked by the therapist both in the more or less "pure" form, and especially in the "disguised" form. In his work with the Bellevue Psychiatric Division, Gould observed a number of children who showed many of the classical symptoms of depression such as: loss of interest in social environment and loss of drive; feelings of sadness and worthlessness; eating disturbances and sleeping difficulties; feelings of loneliness; and hypomotility. Gould reported that depression, along with feelings of loneliness, is an "excruciating state which is generally avoided or masked in the youngster" (p. 253). Some of these "hidden" or "masked" behaviors may be temper tantrums, boredom, restlessness, rebelliousness, defiance, running away from home, "accidental injuries", hypochondriacal preoccupation, delinquency and other acting-out behaviors. Gould explained that in depression, any hate the child has is usually turned inward. It is Gould's belief that when dependency needs have not been met, the child experiences the loss of love which results in feelings of frustration, rejection, hopelessness, inadequacy and guilt.

Burks and Harrison (1962) investigated the symptom of aggression in children and believed it to be a means of avoiding depression. Children who were experiencing problems of aggression were treated at the Children's Psychiatric Hospital at the University of Michigan Medical Center. Burks and Harrison believed that the major
difficulty experienced by these children was the inability to form lasting love object relationships. They described the nature of depression as one which is characterized by a sense of helplessness or impotence of the ego. Accompanied with this sense of helplessness are feelings of inadequacy and hopelessness. The major behaviors exhibited by these children included acting-out, denial, hypochondriasis, and most other types of non-conventional, anti-social responses. Burks and Harrison reported three kinds of situations which seemed to show that the child had recognized his depressed feelings and then avoided them by involvement in aggressive behavior. The first situation, and most frequent one, was where the child's self-adequacy and omnipotence was being threatened. The second situation was where the child, once recognizing some of his positive feelings towards an adult and his need for affection, felt threatened. The third situation, which was the least frequent, but most marked, was where the child remembered an experience from his past that had apparently reinforced feelings of worthlessness.

Toolan (1962) saw that the common denominator in depressive reactions in children was the loss of a love object, most frequently the mother. Further support for this notion was provided by Benedek (1956), Bowlby (1951), Klein (1948), and Spitz and Wolf (1945).

In 1969, Mattsson, Seese, and Hawkins reported the following symptoms of clinical depression in 75 children seen over a two-year period (July, 1963 through July, 1965) at a child psychiatric clinic at University Hospitals, Cleveland: withdrawal, changes in mood and school performance, loss of initiative and self-esteem, crying spells,
sleep disturbances, decreased appetite, and reduced motor activity.

Statten (1961) investigated childhood depressive states in the form of homesickness. This feeling, he proposed, is manifested in a variety of ways and is not always associated with feelings of being away from home. Actually, it serves as a means of escape from anxiety arousing situations created by the presence of strangers (Statten, 1961). Further, homesickness is a way of attracting attention in a lonely situation and manipulating others' concern and sympathy (Statten, 1961). Statten maintained that when this state in the child is usually associated with separation from home, it is indicative of an underlying depression. The most common symptoms of the depressive state characterized by homesickness are: crying, loneliness, despondency, poor appetite, inactivity, and the desire to return home (Statten, 1961). Other symptoms associated with the stress and anxiety of this depressive state are sleeping difficulties, abdominal pain, headache, constipation, diarrhea, and vomiting (Statten, 1961).

Chwast (1967) investigated masked depressive symptomatology in delinquent children. In his description of "masked" depression, Chwast believed this syndrome to be "perceived as part of the continuum which occurs, most likely at one end of the depressive spectrum, that is that section immediately prior to the point at which depression achieves visibility" (p. 575). In his investigation of 121 children from the Juvenile Aid Bureau of the N.Y.C. Police Dept., Chwast looked for those signs of depression that may be disguised by anger, acting-out, or psychosomatic preoccupations. Using a five-point scale of depression: 1-none; 2-little; 3-somewhat;
4-substantial; and 5-predominant depression, Chwast reported some significant results. First, regarding the total sample of 121 delinquents, 26 (21.5%) or about one out of five children showed "little" or "no" depression (ratings of 1 or 2). The remaining 95 (78.4%) showed 39 children or almost four out of five who were either rated "somewhat" (3) depressed, and 56 (46.2%), almost one out of two, who were rated "substantially" (4) or "predominantly" (5) depressed. Second, for the age group 6 to 13, thirteen children (31%), almost one out of three showed "little" or "no" depression (ratings of 1 or 2); while about one out of four were rated "substantially" (4) or "predominantly" (5) depressed. Chwast, in reviewing his findings, was aware that his study lacked a control group, needed a larger sample so as to allow for intra-group comparisons, and hoped that these findings would be replicated under more satisfactory research conditions. However, Chwast justified his position by claiming that the data in their present form served the purpose of allowing others to draw inferences from all of these cases of clinically examined children rather than overgeneralize from a few. Chwast confirmed that depression in both its overt and covert forms is frequently seen among delinquents. While Chwast did not regard depression as fitting into any diagnostic framework, he did associate it with behaviors resulting from serious emotional and social maladjustments.

Toolan (1962) described "depressive equivalents" in children as being those behaviors marked by boredom, restlessness, temper tantrums, disobedience, masochism, running away from home, accident proneness, etc., and any other form of behavior which serves the
purpose of displacing depressive feelings. According to Toolan, the child is convinced that he is no good, unworthy, evil, or unacceptable as a result of the emotional deprivation which has led up to this state. These feelings lead him to anti-social behavior which in turn further reinforces his feelings of inadequacy (Toolan, 1962). Regarding the latency age child, Toolan claimed that the evidence for depression is less clear-cut. It is more frequently here where a masking element is operating and the child, especially a male, will hide his true feelings and deny any sense of unhappiness. The "smiling depression" that the latency age child will often demonstrate occurs when he or she masks true depressive feelings by exhibiting behaviors which are pretential of happiness. Toolan explained that there are dynamic forces in operation which indicate that the child is suffering from a severely impoverished self-image, and a "profound emptiness of ego comparable to the emptiness of the schizophrenic ego" (p. 410). The child who has experienced a real or perceived loss of love will tend to become disturbed primarily in the development of the ego (Toolan, 1962). Further, marked impairments of the emotional and intellectual dimensions will accompany this ego impairment (Toolan, 1962). Ultimately, the superego becomes affected as a result of this disturbance and will tend to inhibit normal functioning of the personality structure (Toolan, 1962). Toolan stated that in the latency age child, an ambivalent situation is created where he is brought to hate the lost object (usually a parent) whom he feels has betrayed and abandoned him, while still seeking love and support from that object. When the child sees that
things have not changed and that he is still deprived of love, he begins to deny the reality of the situation while blaming himself for this misfortune (Toolan, 1962). The younger assumes his own guilt as the one responsible for this condition, while maintaining a belief in the innocence in his parents (Toolan, 1962). Toolan claimed that as the child grows older and reality testing improves, feelings of hostility eventually become directed toward his parents and he no longer sees them as innocent. Consequently, the processes of intro­jection and identification in the formation of the superego become thwarted and the depressed child continues to vacillate between love and hate. (Toolan, 1962).

Poznanski and Zrull (1970) investigated the existence of affective depression in children. Their research involved the evaluation of case records from the out-patient department of Children's Psychiatric Hospital, at the University of Michigan Medical Center. There were two main objectives in their study: First, to find clinical correlates which would aid in the recognition of depression in children; and second, to find common denominators which would enhance the knowledge concerning childhood depression in relation to age, behavioral patterns, past history, and family relationships. Within the period of four years, 1964-1968, 1,788 children were seen at the University of Michigan Medical Center. The various behaviors of each child were observed and coded in order to investigate the presence of depressive symptoms. These symptoms would then be rated as: (1) none or slight; (2) mild; (3) moderate; (4) severe or predominant; and (5) unknown. Depressive symptomatology was not previously defined for
the raters; therefore each rater used his own conceptual model. As a result, a wide variety of depressive behavior was recorded, often without any indication or basis for why the rating was made. When those cases of depression were finally chosen, there was substantial evidence of similar symptomatology recorded in the case histories of those children. First, the records of children who were either rated as "moderate", "severe", or "predominant" were reviewed. In this category, there was evidence of 32 cases of children who were 6 years of age and under. Second, the records of just those children who were rated as "severe" or "predominant" were reviewed. There were 66 children in this category between the ages of 11 and 12. From this subtotal of 98 children, 14 were selected because their clinical descriptions strongly indicated a more serious pathology, and they were initially able to describe these feelings of sadness and discontentment in the clinical interview. Of the 14 children, 11 were boys and 3 were girls. The age range consisted of the years from 3 through 12, with a greater percentage of children being represented in the 9 through 11 age group. Depressive symptomatology evidenced in these children included: sadness, unhappiness, withdrawal; feelings of rejection; insomnia; and autoeroticism. Frequently noted was the projection of a negative self-image, feelings of defeat and incompetence, and a view of the world as hostile. When asked which words would describe themselves adequately, some of the children used such words as "mean", "stupid", "punk kid", or "dum" (Poznanski and Zrull, 1970).
When a child's attempts at regaining a gratifying object have been thwarted, Malmquist (1971) noted that four different kinds of behaviors will be evidenced: (1) there will be a persistent and unconscious desire to recover the lost love object; (2) anger against the self and others will become displaced and the child will experience guilt because he feels partially responsible for the loss of love; (3) a mechanism Malmquist terms "projective identification" will occur in which the child becomes absorbed in caring for others who are suffering and experiences a vicarious mourning or related feelings; and (4) a "splitting of the ego" will result when denial of the permanent object loss occurs (acute losses are believed to have a greater tendency to result in such denial, according to Malmquist). Malmquist contended that both those children who have actually experienced the loss of love and those who have perceived such a loss will exhibit these behaviors. Consequently, as the child believes he is no longer in control of the situation, he becomes overwhelmed with feelings of loss and inadequacy. The phrase "depressive mood" was used by Malmquist to refer to the child who has experienced a separation or grief reaction. Frequently, the child masks these moods by exhibiting temper tantrums (Malmquist, 1971). He makes continual attempts to woo or coerce the mother, but gives up for a while and surrenders almost to the point of masochistic resignation (Malmquist, 1971). Sometimes anger may persist for a greater duration while grief and sadness have already been resolved (Malmquist, 1971).
Symonds (1966) claimed that behavioral correlates are essential diagnostic cues in the depressions of children as they are with most emotional problems of children. The example of the sad child who does not act "sad", but rather "bad" was illustrated by Symonds. Here, the child will overtly defy, provoke and antagonize others in an effort to manipulate for his attention needs, and alert others to his sad feelings. Another form of behavior reflecting the child's feelings of sadness is passive resistance (Symonds, 1966). Symonds referred to this as "oppositional behavior" where the child responds with a "no" to whatever request, albeit good or bad, is presented. This form of behavior was regarded by Symonds as self-destructive as well as demonstrating a depressive reaction. Another form of behavior regarded by Symonds to be diagnostic of depression is the comical wit or "class clown" image. Here, the child is reinforced by his classmates for openly defying the teacher's authority and becoming the target for unanimous ridicule (Symonds, 1966). The child purposely behaves in a transparent fashion in order to get caught and punished so that he will continue getting reinforced for his anti-social behavior (Symonds, 1966).

A constellation which would comprise the depressive mood in children and perhaps resemble a depressive state in the adult was investigated by Sandler and Joffe (1965). A series of 100 cases were reviewed at the Hampstead Child-Therapy Clinic, in which many children were described as exhibiting a "depressive reaction" to a wide range of internal and external precipitating situations. Sandler and Joffe recorded a combination of some of the following inter-related
features recorded in a wide range of cases:

(1) the child appeared to be sad, unhappy, or depressed; (2) signs of withdrawal were evident and the child was reported as having little interest in anything from time to time; (3) there appeared to be a feeling of discontentment, and the child seemed to lack the capacity for pleasure or becoming readily satisfied; (4) a sense of feeling rejected or unloved was portrayed, and the child showed a readiness to turn away from disappointing objects; (5) the child was not prepared to accept help or comfort, and even if he did ask for it or appeared to accept it, there would emerge a feeling of disappointment and discontent; (6) there would emerge a general tendency to regress to oral passivity; (7) insomnia and other sleep disturbances were noted; (8) autoerotic activities were also evidenced; and (9) the child was usually reported by the therapist as experiencing difficulty in interacting with that therapist. (p. 90)

The dynamics provided by Sandler and Joffe in the above investigation are essential in understanding the forces operating in the depressed child. Primarily, there is the matter of understanding depression as a basic affective response. These investigators claimed that this reaction, like anxiety, is a normal and appropriate affective response which can be of long or short duration, and of mild, moderate, or severe intensity. A second concept, according to Sandler and Joffe, is the depressive reaction and its relationship to loss. Here, the child experiences a sense of threat to his own state of well-being as a result of real or perceived loss and may adopt an attitude of passive resignation towards his environment. A third consideration is given to the concept of depressive affect and pain. In relation to this, Sandler and Joffe stated: "While the basic affective state of depression is not identical with pain, it is what
might be described as a state of helpless resignation in the face of pain, together with an inhibition both of drive discharge and ego functions" (p. 92). Aggression and the depressive reaction is the fourth aspect of discussion provided by Sandler and Joffe. Regarding this aspect, the child will experience the depressive response when there is undischarged aggression. When anger has not been directed toward the appropriate object, it will be turned against the self and result in guilt feelings. The child will then be forced into a state of helplessness as feelings of impotence and ineffectual rage have not been expressed. Sandler and Joffe described a fifth dynamic aspect that is related to the role of defenses in the depressed child. When the child cannot tolerate frustration appropriately, nor deal with aggression, he may regress to an earlier phase. Such behaviors as thumbsucking, day-dreaming, and obsessional rituals can help the child defend himself against depressive affect (Sandler and Joffe, 1965).

Cytryn and McKnew (1972) proposed a system of classification of depression in latency age children. Three categories were described: (1) masked depression, in which overt behaviors disguise an underlying depressive conflict; (2) acute depression, in which there is a reaction to an immediate trauma such as a real or perceived loss of love, or birth of a sibling; and (3) chronic depression, in which there is a more permanent syndrome fixed within the lifestyle and personality structure of the child. In a study of 37 children aged 6 through 12, referred by many different sources, Cytryn and McKnew sought to investigate children within each nosological consideration.
In the case studies of children who were diagnosed as having masked depression, there appeared to be a more severe display of psychopathology both in the family and in the child himself. Unlike acute and chronic depressive reactions of childhood, masked depression is seen very often although it frequently goes unrecognized. In those children experiencing the acute depressive reactions, they were basically well adjusted prior to the precipitating event, even though there was usually some mild family psychopathology. Children who were described as chronically depressed had a history of marginal premorbid social adjustment to depression. They also experienced repeated separation from significant love objects, and at least one parent had a history of recurrent depressive episodes. Treatment of all 37 children was instigated in the form of chemotherapy and psychotherapy, and lasted anywhere from three months to two years, depending on the severity and prognosis of each child. The follow-up period varied from case to case, but ranged from one to three years. Findings indicated that all patients who had received treatment showed marked improvement. However, follow-up showed that chronically depressed children who had been treated had more difficulty adjusting to an unmodified family environment than did those children who had been treated for masked or acute depressive reactions.

Lesse (1974), another proponent of the concept of masked depression in children, used the term "depressive equivalents". According to Lesse, depression often goes unrecognized in children because it is frequently hidden in symptoms not readily identifiable. Lesse described these children as "loners" since they usually show impairment
in interpersonal functioning. While these children have frequently been misdiagnosed as childhood schizophrenics, Lesse claimed that this underlying depressive state may be revealed by symptoms of school phobia, hypochondriasis, headache, tics, cramps, nausea, impulsivity, anger, and rebelliousness.

That school phobia is a manifestation of depression was also investigated by Agras (1959). He cited Johnson (1941) who pointed out that the basic problem in a school phobic child was separation-anxiety. The dynamics have also been described by Johnson, who claimed that the relationship between the child and mother is one of unresolved dependency, characterized by mutual hostility derived from early childhood (Agras, 1959). The outbreak of school phobia depends upon some type of marital stress such as unfaithfulness, sickness, or financial pressure, coupled with a simultaneous threat to the child's security such as an illness, accident or some upsetting change at school (Agras, 1959). These incidents further increase the child's dependency needs which the child feels have been thwarted by his mother. Hostility towards mother is then increased, but displaced on to the teacher or some other school-related situation. Agras, at the Montreal Children's Hospital, investigated seven cases of children with this school phobic syndrome in relationship to depressive symptoms. The psychopathology of the family was also evaluated, and the child was selected on the basis that some fear of school was expressed. Among these seven subjects, four boys between the ages of 6 and 9½ were included as well as three girls between the ages of 6 and 12. The symptoms were categorized as follows: openly expressed fear
of going to school; depressive or manic symptoms; somatic complaints; and other fears and paranoia. Depressive symptoms included frequent outbursts of crying for no apparent reason, coupled with unhappiness and whining behavior which showed the child to be miserable. Although Agras used too small a sample to formulate conclusions that may be generalized, his findings suggest that school phobic children may actually be experiencing an underlying depressive disorder. It has also been indicated that these children are experiencing a depressive reaction which is related to separation-anxiety and family stress.

Shaw (1972) described two main types of depression that occur in children. The first type is apparent in infants less than two years old and occurs as a result of separation from the mother. This form has also been previously described by Benedek, 1956; Bowlby, 1951; Engel, 1962; Klein, 1948 and Spitz and Wolf, 1946. The second form regards the depression that occurs in children aged 6 and older. In the second situation, the child is involved in a conflict where he becomes overwhelmed with feelings of hopelessness and despair. The depressive feelings are related to some perceived or actual loss of love, usually a parent. The child experiences a sense of "giving up" which is reflected by feelings of sadness, apathy, lethargy, oppositional behavior (such as passive-aggressiveness), and physical symptoms such as headache, vomiting, cramps, constipation, and transient pain.

Solomon and Patch (1974) contended that there is no classical syndrome of depression in children that is similar to the one known
in adults, but there are dynamic similarities in both. For example, in both cases there tends to be an unconscious infantilism versus a strict, rigid, punitive conscience. These authors described what is known as an "emotional hunger" felt by these children, in which an insatiable demand of love and attention is placed on the environment. Some of the symptoms that might be manifested are obesity, hypochondriasis, accident proneness, running away, ulcerative colitis, and anorexia.

The Group for the Advancement of Psychiatry claimed in 1974 that psychoneurotic depressive disorders are seen in children in a more acute rather than chronic form. The acute form indicates a more immediate, reactive, onset which will dissipate with time. The chronic form believed to be found more frequently in adults, involves internalized conflicts in relation to deeply ambivalent feelings.

Klagsbrun (1976) claimed that the classical symptoms of clinical depression such as withdrawal, crying, inability to sleep and eat, do not present the complete picture of depression in younger children. There tends to be more of a masking, concealed, and often misinterpreted element, since children tend to act out their feelings rather than talk about them. Since the lines between masked depression and true clinical depression are not always clearly delineated, a child may vacillate between angry and destructive behavior on the one hand, and silent withdrawals on the other. The true element underlying most depressions is the sense of a profound real or imagined loss of love (Gould, 1965; Klagsbrun, 1976; Malmquist, 1971; Toolan, 1962). Klagsbrun held the belief that the depressed child is
overwhelmed by feelings of inadequacy and a sense of worthlessness. He feels unworthy of experiencing or receiving love.

Mahler (1961) proposed that when a child experiences a "depressive mood", he is experiencing what originated during a process in infancy described as "separation-individuation." In the process of separation-individuation, the child experiences anxiety as he sees his dependency status being threatened by progressive separation from his mother. Mahler claimed that this "depressive mood" experienced in childhood is simply an exaggeration of the separation-individuation process which occurred previously in infancy. Eventually, the young child becomes more and more aware of himself and his parents as separate individuals (Mahler, 1961). He is able to recognize that his mother no longer caters immediately to all his needs. It is when the mother becomes deficient in the child's eyes, that his self-esteem suffers and he is more likely to develop depressive moods. As a result, there arises an observable change in the child's behavior in which he becomes demanding, forceful, clinging, angry, and insecure (Mahler, 1961).

Mosse (1974) investigated masked depression in children who were known to have suffered the "battered child syndrome." Believing that maltreated children are always depressed, Mosse claimed that they frequently cover up their feelings in order to avoid further abuse. The symptoms which are typically seen in these children, according to Mosse, include: an inability to concentrate; shyness; withdrawal; daydreaming; excessive fears; preoccupation with death, the dark, the devil, punishment by God, wars, etc. Frequently, the child will have
nightmares, hallucinations of monsters, will not participate in family life, will not play with other children, and spend a lot of time viewing television. Mosse contended that symptoms of school phobia, reading and other learning disorders are often typical symptoms of masked depression. Accompanying such behaviors are: an inability to concentrate; preoccupation with sad fantasies; feelings of inferiority; and the progressive slowing down of all reactions (Mosse, 1974).

Anthony (1975) described what he believed to be the reason why depression in children is often overlooked:

There is an old clinical truism that diagnoses are made after a diagnosis has been made, meaning that once a clinical state has been recognized and described, the less perceptive begin to see it... There are, of course, many reasons for not seeing what is abundantly manifest, and clinical depression in childhood could be one of those conditions for which adults (even analytically trained ones) develop a surprising blind spot. (p.252)

The psychodynamic studies presented, strongly suggest the concept of depression in children to be valid, particularly within the latency through preadolescent age range. The more pertinent literature regarding description and theory was investigated in order to facilitate a better understanding of this topic within the psychodynamic orientation.

Alternate models of depression in children are also provided in the comprehensive literature, some of which will be discussed below. However, the reader is alerted to the limited amount of research regarding depression in children within the Behavioral, Environmental,
and the Phenomenological literature. Some of the more substantial Behavioral positions are presented first.

**Behavioral, Environmental, and Phenomenological formulations.**

Bandura (1969) proposed that depression is a deviant form of behavior in which the purpose of escape or avoidance is fulfilled. Hence it could be postulated that children who face a threatening and anxiety-provoking situation will resort to becoming depressed, rather than meet the demands of that situation. Bandura associated depressive reactions with any other problems that frequently result from dysfunctions in self-reinforcement systems. When a negative self-image is generated because of feelings of decreased worth and lack of purpose, the child develops a "lessened disposition" to perform and the processes of escape and avoidance become evident (Bandura, 1969).

Seligman (1973) derived the model of "learned helplessness" and related it to depression. He contended that when someone becomes depressed, he is believing in his own helplessness. Seligman claimed that learned helplessness and depression share common features as far as symptomatology and precipitating events are concerned. The experimental analog for certain reactive depressions is provided in the study of "conditioned helplessness" conducted by Maier, Overmier, and Seligman (cited by Seligman, 1973). In this study, experimental neuroses were produced by administering strong inescapable electrical shocks to dogs (cited by Seligman, 1973). Eventually, the animals, after repeated behaviors of howling, urinating, defecating, and running around frantically, accepted the inevitable shock. The dogs no longer tried to escape the shock by crossing the barrier of his
shuttle box, but whined and appeared to remain helpless. Seligman emphasized in reporting this study that it was not so much the trauma of the electric shock that interfered with the dog's adaptive functioning, but the experience that it no longer had control over the environment. Likewise, it has already been demonstrated that when animals are able to control shock, they do not later become helpless (Seligman, 1973). Applying Seligman's model then to the condition of depression in children, it can be said that a child will show a reduction in responding when his efforts to control or modify his environment have proven futile. Ultimately, he will assume a passive attitude in the belief that he is helpless and that nothing he can do will change the way he feels.

Wolpe (1973) distinguished between normal and abnormal depression. According to Wolpe, in normal depressive reactions, individuals who have experienced a loss or deprivation of some kind will seek substitution of new objects. Wolpe claimed that normal depressive reactions actually aid in the adaptive responding to loss, such as in the case of the child who seeks a mother substitute after prolonged separation. Abnormal or "pathological" depressive responses are where the individual exhibits behaviors which do not serve to restore the loss of love and are excessively severe and prolonged (Wolpe, 1973). Wolpe is suggesting that in this pathological state, there is a greater impairment in reality testing such as in the cases of chronically depressed children previously described by Chwast (1967), Cytryn and McKnew (1972), Glaser (1967), Poznanski and Zrull (1970) and Toolan (1962).
Wahler and Pollio (1968), in their study of 8 year-old "Joey", tried to experimentally assess relationships between changes in a child's deviant or depressed behavior, and his verbal description of that behavior. Behavior modification, using operant reinforcement principles, was applied where adult interest and attention were utilized in the alteration of Joey's behavior. Before Joey was treated, he was characterized by his parents as "passive", "depressed", "emotionally constricted", and extremely "dependent" on others.

In evaluating Joey's behavioral repertoire, five response classes were considered: (1) smiling; (2) spontaneous verbal (verbal behavior with no observable cue provided by others); (3) spontaneous non-verbal (changing interactions with objects or people, with no observable cue); (4) aggressive behavior (shouting, running, throwing, play fighting); and (5) cooperative behavior (following suggestions or commands from other people). Additionally, fourteen words were chosen on the basis of face validity which appeared to be semantically related to Joey's deviant behavior. These words were: alone, school, help, fight, father, mother, teacher, doctor, stranger, friend, me, dinner, bedtime, and baby. Basically, these words represented significant people in his environment and areas of immediate concern. Wahler and Pollio claimed that these words also represented dependency concepts held by traditional psychotherapies. In 24 twenty-minute sessions which occurred twice a week, either parent served as the primary behavior modifier, along with a professional therapist. Wahler and Pollio sought three goals: (1) to increase the frequency of Joey's smiling, spontaneous verbal, spontaneous non-
verbal, aggressive behavior; and to decrease cooperative behavior; (2) to assess the relationships between frequent changes in these response classes and changes in Joey's rating of selected words; and (3) to demonstrate experimentally that any change in overt conduct or in semantic rating behaviors was due to modification of the social attention contingencies. The outcome of the study provided empirical data of Joey's transition from a depressed and possibly suicidal child at the onset of therapy, to a more appropriately functioning and effective child after the 24 twenty-minute reinforcement sessions. This single case presentation suggests that depression, as a deviant behavior, is modifiable via the instigation of reinforcement principles.

Further evidence that depressive behavior in the extremely withdrawn child is treatable using reinforcement principles comes from the study by Allen, Hart, Buell, Harris and Wolfe (cited by Bandura, 1969). Also, depressive behavior in extremely passive children is alterable as reflected in the research of Johnston, Kelley, Harris and Wolf (cited by Bandura, 1969).

As with the Behavioral literature on childhood depression, there is limited research from those who hold the more Phenomenological models. However, an attempt will be made to cite some essential models of conflict theory, and hopefully the reader will see the application of these principles to depression in childhood.

Martin (1972) provided a model of neurosis based on conflict theory with four characteristics: (1) painful emotions such as anxiety, guilt, and depression; (2) low self-esteem; (3) impaired
problem-solving ability; and (4) self-defeating behaviors or "symptoms." These elements bear close resemblance to the descriptions of depression in some of the previous theories mentioned in this manuscript. Martin described the nature of conflict as being "the tendency to perform two or more incompatible responses at the same time" (p. 33). In the depressed child experiencing a psychoneurotic conflict, one hypothetical application of Martin's model may be that the child is experiencing simultaneous behaviors of some sort such as passive-aggressive needs; dependency-independency needs; or ambivalent feelings of love-hate in the case of object loss. Martin cited the approach-avoidance theory of conflict derived from Dollard and Miller, on which he believed much of his own model was based. Essentially, this model of conflict according to Martin, refers to the situation "in which the organism has a tendency to approach separate goals, with the approach of one goal resulting in the loss of the other" (p. 34).

The Gestalt theorists, according to Martin (1971), view neurosis as a breaking down in the process of progressive formation which is then followed by the destruction of "organized gestalts" (p. 64). Apparently, the neurotic is not expressing his inner needs appropriately while at the same time viewing the external world inaccurately. There is an impairment within the organization of the personality which impedes "full organismic reality with the self and the environment" (Martin, 1971, p. 64). The neurotic fails to express and act in response to his needs, repressing significant experiences which prevent the formation of powerful gestalts (Martin, 1971). It is
questionable whether the Gestalt model can be applied to very young children, since it requires complex and more mature processes of insight and self-awareness. However, with the older child who has matured cognitively, this model may be more appropriate in furthering the understanding of psychoneurotic conditions such as depression.

Rogers (1959) formulated a theory of neurosis which proposed that an individual develops "incongruence between self and experience" (p. 203) when there is a conflict between the perceived self and the actual self-experiences. In order to keep these experiences consistent with his conditions of worth, the person attempts to cope with this conflict by selectively perceiving his own self-experiences (Rogers, 1959). Even when behaviors such as "actualizing experiences" (p. 196) violate the individual's conditions of worth, they too will be distorted by his perceptions. According to Rogers, anxiety occurs when conditions of worth become jeopardized, resulting in conflict between these conditions and experiences that are motivated inward. It is at this point that the person no longer feels "positive regard" (Rogers, 1959). In the depressed child who is experiencing a sense of loss of self-esteem, Rogers explained that defenses against such resulting anxiety characterize emotionally disturbed behavior. Such a defense process distorts the incongruent self experiences and keeps them consistent with the individual's self-structure and conditions of worth (Rogers, 1959). By distorting objective reality with the adequate utilization of defenses, the individual may continue to cope with frustration (Rogers, 1959).
Applying this principle to the psychoneurotic condition of the depressed child, it could be postulated that some of these defenses may be recognized as aggression (Burks and Harrison, 1962), denial and anger (Klagsbrun, 1976), acting-out and projection (Toolan, 1962), and rationalization (Schrut, 1964).

Rogers' concepts are related to Maslow's theory of Self-Actualization, thus some of those ideas will be reviewed. Based on a hierarchy of needs, Maslow presented five stages which should ideally culminate in self-actualization, as outlined by Morgan and King (1966):

1. Physiological needs such as hunger, thirst and sex;
2. Safety needs such as security, stability, and order;
3. Belongingness and love needs such as needs for affection, affiliation, and identification;
4. Esteem needs, such as needs for prestige, success, and self-respect;
5. Self-actualization that develops out of the full potentials of the person. (p. 494)

Hypothetically, stagnation at any of the primary stages may impede the growth process and self-actualization may not be attained. This model may be applied to describe the condition of the depressed child. For example, the depressed child may have fixated at an earlier stage of Maslow's model; e.g., stage 3, if he has experienced the loss of a love object. Further, the lack of fulfillment of needs at stage 3 may cause the child to regress to stage 2 in which his safety needs have also been ungratified.

In evaluating the limited Behavioral and Phenomenological literature, it is evident that there is a need for further research in the area of depression in children. Although the theories presented do
contain value when adequately interpreted and applied to children, there is still an overemphasis of depression in adults. Especially, in the case of the Phenomenological orientation, it is more difficult to fit into a more adult-oriented framework. Perhaps the problem common to all essential models, including the Psychodynamic viewpoints, is the lack of uniform criteria in the definition of depression in children. Currently, there appears to be more speculation than conclusive evidence. There is a need to concentrate on establishing both a more scientific and clinical definition of depression in children that may fit into the frameworks of all essential models.

The Depressed Personality

Predisposition to Depression

Burks and Harrison (1962) described the phenomenon of the "deprived child" where the child is separated from his mother at a crucial stage, or in a situation where the mother figure is physically present but not meeting the child's needs maternally. "Affectionless child" characterizes the child who has: "the makings of the constitutional psychopathic inferior -- an empty, hedonistic, impulsive, and guilt-free person" (Burks and Harrison, 1962, p. 418).

Poznanski and Zrull (1970) described the depressed child as one who has feared failure, has anticipated the world as hostile, has experienced feelings of inadequacy, self-criticism, demeanor, and has had "a deeply rooted sense of badness" (p. 463).

Fast was cited by Poznanski and Zrull (1970), who claimed that
a child may be predisposed to depressive illness in terms of "sets" and "boundaries." A transition from a good/bad self-image boundary, where good is within the child and bad is outside the child, to a boundary where both good and bad are integrated within the child is of critical importance according to Fast (cited by Poznanski and Zrull, 1970). Fast also postulated that the child becomes predisposed to depression when that second set of boundaries that has been described has failed to become established (cited by Poznanski and Zrull, 1970).

Anthony (1975) has cited Engel, who has observed that some infants respond to frustration with a reaction described as "inhibition-withdrawal" and then with "depression-withdrawal," while others become predominantly anxious. As the child becomes older, the differences are fairly noticeable where some children may react to frustration with anger, protest, and resentment, while others become depressed and helpless.

Malmquist (1971) described the concept of depressive proneness in children as it relates to object loss and its nature in relation to grief. For example, when a child experiences the loss of a mother figure between six months and three or four years of age, it is evidenced that there is a greater potential for pathogenesis in the development of the personality. First, the child will tend to maintain a persistent and unconscious yearning to recover lost objects, even when the grief has not been conspicuous; second, anger toward others is displaced onto the self and further, guilt may arise if
the child believes he has had a role in the loss; third, there will be a preoccupation in caring for others who are suffering in an attempt to allow for projective identification by vicarious mourning; and finally, a "splitting of the ego" may result if denial in the permanence of object loss is occurring. Malmquist believed that losses predispose the child to the development of a depressive nucleus. If his self-concept is made up of repeated introjections of self-depreciation, feelings of unworthiness, and negative evaluations of others, the child will develop angry, distant, behavior which will increase interpersonal isolation from family and friends. This conflict can become further intensified if the child has an exaggerated fear of punishment, loneliness, despair, detachment, and abandonment.

Sandler and Joffe are cited by Anthony (1975) to describe the influence of constitutional factors in depression as: "the predisposition to use particular defenses, frustration and discharge thresholds, differences in the apparatuses of primary autonomy, and variations in drive endowment" (p. 242-243). Other investigators who believed that the presence of constitutional factors play a role in the depression of children include: Benedek (1956), who stressed the congenital inability of some infants to be satisfied due to an hormonal dysfunction; Freud (1914), who claimed the predisposition to depression included the constitutional increase in both ambivalence and orality in the experience of object loss and a regression to narcissism; Klein (1948), who spoke of a constitutional excess of oral sadistic envy in relation to the child predisposed to depression; and Rado (1928), who stressed orality and the sequence of rage-
guilt-atonement-forgiveness in the context of hunger followed by or-gastic satisfaction of the breast, and that the repetition of this sequence eventually creates the predisposition to depression.

Symonds (1966) claimed that children with depressive proneness are typically chronically pessimistic and usually face the future with apprehension. When a child has been met with repeated failure, he becomes overwhelmed by feelings of hopelessness and severe resignation. Essentially, they appear to struggle for mere survival and are viewed as "touch-me-nots" because of their extreme sensitivity and avoidance of others (Symonds, 1966). A state of ambivalence is sometimes created in the depressed child. The child, while experiencing intense feelings of loneliness, is afraid to become intimate with others while desperately craving for adhesiveness. Symonds used the term "Charlie Brown Syndrome", to describe the personality structure of depressive prone children. According to Symonds, the child who is pessimistic tries continually to lighten his load by acting hopeful despite the misfortunes he encounters in life. This process of denial serves to prevent the child from facing the reality of the situation. Symonds described this avoidance as one that occurs with disillusionment, despair, and rage: "You see, I'm a good boy. I keep on trying. I'm not mad at anyone but me" (p. 191). The "Charlie Browns", according to Symonds, are in actuality very angry children who suppress that anger by passive resistance. They typically hate themselves for their passivity, and try to overcome this inadequacy by appearing humorous and benevolent. It is as if these children continuously seek victims upon whom to express their
helpless rage. Symonds cited Horney, who claimed that the depressed child is encumbered with feelings of helplessness and hopelessness, and will resort to a more permanent resignation of life in order to avoid conflict. Ultimately, Symonds regarded the depressed child as merely concerned with endurance and survival and not with the benefits of goodness of life.

Cytryn and McKnew (1972) described the premorbid personality patterns of the acute, chronic, and masked depressive child. In the acute cases, these children had basically been well adjusted prior to the precipitating factor that allowed for the onset of the illness. Although they had a history of sound and stable personalities, there were some persistent traits of exaggerated stubbornness and other passive-aggressive behaviors. Those children with chronic depressive episodes showed a premorbid history of serious emotional maladjustment, with intense feelings of loneliness, dependency, helplessness, and passivity. They also showed recurrent episodes of depression in early childhood that would last from several days to several months at a time. In contrast to the children who were described as acutely depressed, the chronically depressed children showed a low tolerance to even minor trauma and lacked the customary defenses that would protect themselves against depression. Those children with masked depressive reactions appeared to utilize a variety of defenses even under the most severe situations of stress. Although these children were able to ward off depression, their defenses were actually maladaptive and often led to a serious breakdown in overall
functioning, a conflict with the environment, or some type of psychosomatic illness.

Seligman (1973) used the term "born losers" to describe the character make-up of the depressed individual. According to Seligman, it is not so much the depressive's pessimistic attitude on life that sets him apart from others, but rather the belief in his own futility. Seligman cited Beck, who used the term "negative cognitive set" to be the primary characteristic of the depressed individual. Beck claimed that here the person interprets any obstacle as a failure on his part to effect any change in a problematic situation, and hence adopts the attitudes of: "I'm licked"; "I'll never be able to do this"; or "I'm blocked no matter what I do" (cited by Seligman, p. 45). The concept of failure and resignation proposed by Beck is consistent with the views expressed by Malmquist (1971), Poznanski and Zrull (1970), and Symonds (1966).

Other viewpoints have been proposed which show aggression to be a variable in the personality of the depressed individual. Seligman (1973) claimed that depressed persons usually lack aggressiveness as well as the normal competitiveness that is expected of a healthy, coping individual. He also claimed that they are deplete of hostility and in instances where anger is appropriate, they choose to remain silent, helpless, and passive. Poznanski and Zrull (1970) on the other hand, found that children who were characterized as depressed, frequently showed outbursts of anger and physical aggressiveness.

Further investigations of the depressed personality have been provided by Anthony (1975), who claimed that these children
frequently had difficulty handling and accepting disappointment; Malmquist (1971), who saw that children who were repeatedly exposed to deprivation, neglect, rebuffs, and loss, developed negative impressions of themselves which appeared to markedly impair reality testing; and Schaffer (1974), who described these children as intellectually superior and impulsive.

Precipitating factors of depression. Among all the various causes associated with depression in childhood, the loss of a love object, usually the mother, has been the most prominent (Cytryn and McKnew, 1972; Gould, 1965; Klagsbrun, 1976; Sandler and Joffe, 1965; Schecter, 1957; Shaw, 1972; Spitz and Wolf, 1945; Toolan, 1962). It was evidenced that either real or imagined loss of love was capable of producing either acute, chronic or masked depressive reactions in children (Cytryn and McKnew, 1972). Frequently associated with the concept of object loss are trauma such as a death of a parent; separation or divorce between parents; and birth of a sibling (Cytryn and McKnew, 1972; Klagsbrun, 1976; Lieberman, 1954; Poznanski and Zrull, 1970; and Saltzman, 1976). Other situations where the child may become depressed are where his self-esteem and security needs have been threatened (Burks and Harrison, 1962; Cytryn and McKnew, 1972; Toolan, 1962). Specifically, if the child in these instances cannot react with anger towards the appropriate object, he may turn that anger inward and experience a depressive reaction (Chwast, 1967; Freud, 1917; Malmquist, 1971; Schecter, 1957; Symonds, 1966; Toolan, 1962).

In reviewing this concept of the depressed personality in children, various descriptions have been provided which support this
notion. Theorists claim that there are distinctive patterns or "traits" in the personality of the child who is predisposed to depression. Further, it appears that the risk of a depressive reaction is higher when children with the depressed personality experience trauma of some kind.

Family Pathology, Parental Influence and Home Environment

Cain and Fast (1966) observed that children of suicidal parents develop those symptoms comparable to the depressive syndrome. Schaffer (1974) contended that children of parents who were diagnosed as clinically depressed also showed a higher incidence of depression. Cytryn and McKnew (1972) observed that children who were experiencing chronic depressive reactions had at least one parent (in most instances the mother) with a history of recurring depressive illness. In environments where a child has lived with a manic-depressive family member, Anthony (1975) claimed that the youngster is considered to be genetically at risk in developing the manic-depressive syndrome. Malmquist (1971) reported that depressed moods seen in mothers during the first two years after birth could create a similar tendency in their children. The child achieves a sense of unity and harmony with the depressed mother in the process of identification and produces the mood of the mother himself (Malmquist, 1971). Mahler's (1961) view is consistent with that of Malmquist. Mahler claimed that when the mother of a child is depressed, the child may identify with her and become depressed. According to Mahler, when this happens, the mother cannot let go of the child and allow him to "individuate"
which is an essential step in the separation-individuation process (cited by Anthony, 1975). Rie (1966) believed that depressed or anxious mothers of infants who are experiencing sleeping and eating disturbances, crying, colic, head banging, etc., are actually teaching the child to model this same depressive behavior.

Renshaw (1974) indicated that family pathology such as in the form of alcoholism, fighting between parents, physical abuse to children, etc., are frequently found in the histories of depressed children.

Poznanski and Zrull (1970) contended that children who have experienced depressive illness cannot integrate good and bad images of themselves at any one time because their parents have acted ambivalently towards them. Not only have these parents shown inconsistent patterns of approval towards the child, but also a lack of support whenever the child experienced failure. These parents also exhibited a high incidence of depression; emotional detachment from their children; difficulties in handling aggression and hostility; and were overtly rejecting towards the child by such means as pure neglect, partiality of preferred siblings, physical abuse, or death.

Anthony (1975) purported that children who have grown up in environments where mourning, grief, and stress have been concealed will experience unusual depressions when similar circumstances occur in the future. This kind of family environment, according to Anthony, is unrealistic and predisposes the child to exaggerated depressive reactions to seemingly minor trauma in later life. On
the other hand, children who have had excessive exposure to pain, grief, sorrow, despair, neglect and rejection will tend to appear unaffected in circumstances where depressive reactions are considered common (Anthony, 1975). Anthony described these children as becoming "affectionless psychopathic adults" (p. 236), where they would demonstrate as little emotion as possible, even in somewhat traumatic situations.

Agras (1959) described the nature of parents who had school phobic children. Out of 7 cases, 6 of the mothers showed overt signs of depression at the time of the first interview and continued demonstrating these symptoms for several weeks after treatment. Agras referred to the "depressive constellation" to describe the emergences of family patterns of school phobic children. Typically, in this phenomenon there is a tendency towards depression in all the family members, but with greater emphasis on the parents. These parents lack the ability to minimize environmental stress, resolve or tolerate frustration, and minimize as well as avoid situations which are perceived as painful (Agras, 1959).

Parental deprivation or abandonment that has been intentional is also a pathological condition which can result in the depressive illness of the child (Bowlby, 1953; Munro, 1969; Spitz and Wolf, 1945).

In the previous section of this manuscript, the reader was introduced to the subject of depression in children. The literature is becoming more extensive concerning the psychopathology of depression. However, further investigation is needed to provide more substantial
evidence in regard to this subject.

Suicide in children has also become a greater focus of concern in the literature. Since one of the purposes of this paper is to investigate the relationship between depression and suicide in children, the following section regarding suicide will be presented.
Suicide in Children

Prevalence

The reader is referred to the Appendix, where vital statistical data are provided concerning suicide in children between 5 and 14 years of age for various years between 1900-1975.

Schrut (1964) claimed that adolescents and children represent 0.5% to 3% of all suicides in the United States. The Report of the Joint Commission on Mental Health of Children in 1970 stated that the national rate for the adolescent and child population is below one percent and closer to 0.5%. The Commission made this statement regarding very young children: "(Suicide) ... is non-existent under five, virtually non-existent at five to nine years of age, rare between ten and fourteen, increases in frequency about seven to eight fold at ages fifteen to nineteen ...." (U.S. Department of Health, Education, and Welfare, 1966). Lawler, Nakielny and Wright (1963) reported that suicide ranked 13th as a cause of death in the United States during the years 1957 and 1958 in the 10-14 age group alone, as sixty-eight children took their lives. Despert (1952) reported that there were sixty children who had committed suicide in 1947 within the ages of 5-14 years (Appendix). For earlier years, 1926-1929, Kanner (1972) reported a total of 162 suicides in the United States for children between the ages of 5 and 14. For the more current years of 1974 and 1975, the rate of child suicides in the
United States for this same group was 0.6% (U.S. Department of Health, Education, and Welfare, 1976). This 0.6% rate represents 188 children who took their lives in 1974 and 170 who did likewise in 1975 (U.S. Department of Health, Education, and Welfare, 1976).

**Sex Differences in Attempted and Committed Suicides of Children**

Essentially, there tends to be a consistent preponderance of male suicides over female suicides, according to the annual reports provided by the United States Department of Health, Education, and Welfare (1900-1975). Attempted suicides show a greater proportion of females over males (Bakwin and Bakwin, 1957; Despert, 1952; Gould, 1965; Jacobinzer, 1960; Kanner, 1972; Toolan, 1962). The theory has been proposed that more males succeed in committing suicide because they use more violent and aggressive methods than females (Ackerly, 1967; Bakwin and Bakwin, 1957; Bergstrand and Otto, 1962; Despert, 1952; Lourie, 1966; Mattsson, Seese, and Hawkins, 1969; Otto, 1966; Schrut, 1964; Shaw and Schelkun, 1965; Toolan, 1962). Hence, more females use passive methods in suicidal attempts, not so much to succeed in the act, but to send a "cry for help" (Ackerly, 1967; Bakwin and Bakwin, 1957; Bender and Schilder, 1937; Gould, 1965; Jacobinzer, 1960; Kanner, 1972; Schecter, 1957).

**Methods Used in Committed and Attempted Suicides in Children**

Some of the more violent methods that have been used are explosives, firearms, hanging and strangulation, jumping through windows and from high places, and drowning (Kanner, 1972). It has already been mentioned that males tend to use these methods more frequently
than females and succeed in their attempts. Females tend to prefer such methods as ingestion of pills, poisoning, wrist slashing, and asphyxiation by poisonous gas (Ackerly, 1967; Bakwin and Bakwin, 1957; Gould, 1965; Jacobinzer, 1960; Kanner, 1972; Toolan, 1962).

Racial Differences in Committed and Attempted Suicides in Children

Vital statistical data along with studies in the literature show a preponderance of Whites over all others in committed suicides (U.S. Department of Health, Education, and Welfare Annual Reports 1900-1975; Bakwin and Bakwin, 1957; Despert, 1952; Kanner, 1972; Toolan, 1962). Typically, White males show the highest rate of suicide over other racial categories, even within the 5-14 age group. Although the child's concept of death is a variable to be found in the motivation of suicide in children, the above information suggests that environmental and cultural factors also play an important role. The question of stress would appear to show cultural variations as the white middle-class male child shows the highest frequency of suicide. However, this aspect is beyond the scope of this paper and will only be mentioned in passing as various studies are presented in the following sections.

The Question of "Accidental Deaths"

Out of all the areas of suicide in children that remain questionable, "accidental deaths" is probably the most undeterminable. Gould (1965) stressed that although only three cases of suicide in children under 10 years of age were reported in 1958, many more went unnoticed, unrecognized, or were covered up and reported as accidents. Bakwin and Bakwin (1957) also believed that the number of
deaths from suicide is probably greater than is considered in the mortality data of the United States. These authors claimed that ordinarily, every effort is made to conceal a suicidal death and to attribute it to accident or other cause. This rationale serves to shield the parents from the shame and guilt feelings that are associated with their child's suicide. Despert (1952) discussed the relationship between the impulsive nature of suicide in young children and "accidental deaths." She stressed that noteworthy in the vital statistical data is the high frequency of accidental deaths for the 5-14 age group. For example, in 1947, in the 5-9 age group alone, there were reported 3,252 accidental deaths. In the 10-14 age group for this same year, there were recorded 2,817 accidental deaths. Despert specified that out of the total number of deaths in the 5-9 age group (3,252), 1,371 of those deaths occurred by being struck by motor vehicles; and in the 10-14 age group (2,817), 904 children also died by the same means. Despert wanted to know how much of this tally included children who deliberately ran out in front of cars as an impulsive suicidal gesture to punish or spite a parent? The statement posed earlier emphasized that it would be difficult to determine such information without the use of appropriate methods. Hopefully, more accurate techniques for assessing the question of accidental deaths will be devised as a greater awareness is generated. Saltzman (1976) reported an official figure of 75 preadolescents who committed suicide in the United States in 1973, as compared to an official figure reported of 3 suicides for this age group in 1958.
The prevalence of suicide in children is not as rare an occurrence as was believed. Its incidence has alerted those who are investigating the psychopathology of childhood. The following section was designed to review some of the descriptive and theoretical evidence of suicide in children that has been provided by the Psychodynamic, Behavioral, and Phenomenological viewpoints, respectively.

Descriptions and Theories of Suicide in Children

Psychodynamic formulations. Schecter (1957) claimed that children learn to use a number of defense mechanisms to deal with "affective states." When the degree of tension is extremely high, defense mechanisms break down, or are not effective anymore. Suicide or "suicidal equivalents" may then appear by such gestures as attacks on the introjected object; i.e., while the child may actually be angry at a parental object, he may turn that anger inward and develop self-destructive tendencies (Schecter, 1957).

Toolan (1962) described the role of the superego in the suicidal child. With the development of the superego in the child, hostility and guilt that was once directed toward his neglecting parents are now redirected inward. This turning inward of aggression frequently precludes the suicide attempt, according to Toolan.

There are multiple determinants in the suicide attempt in childhood, according to Lourie (1966), many of which originate in the first few years. Lourie specified that the step between suicidal ideation and suicide attempt is a small one. Lourie indicated that
when the suicidal act is finally carried out, frequently no parents are around to control it.

Schrut (1964) purported that certain self-destructive children have developed a way of life which has been cued by parental attitudes. According to Schrut, the child has been unable to reach his mother by "good" behavior and thus the manner in which he is to cope with life's difficulties is set. The child is prepared to meet other interpersonal crises with reactions that have a self-destructive quality. Finally, Schrut claimed, the ultimate outcome is the suicide attempt which may bring gratification to the child by punishing his parents. Concerning the phenomenon Schrut called "paradoxical suicidal behavior" he stated, "Beneath suicidal behavior is the continual wish for maternal protection and help which, in some suicidal adults as well as children, results in the 'cry for help' by a suicidal attempt" (p. 89).

Ackerly (1967) believed that when the child experiences early life frustrations and disappointments, he expresses himself by engaging in self-destructive behavior, anger, and rage toward his parents. According to Ackerly, the latency age child who threatens to kill himself is revealing a complicated intertwining of psychic forces that have come about as a result of aggressive drives and increased narcissism. Actually, the child is expressing rage toward his parents by exhibiting self-destructive behavior (Ackerly, 1967). The child becomes overwhelmed with guilt for feeling the way he does about his parents and begins to hate himself. According to Ackerly,
death holds for the child gratifications that have never been met in reality. Further, the child might find in death a better life and a reunion with his "all-giving, good mother" (p. 242) which Ackerly described as "the state of primary narcissism" (p. 242). As for the child who has already attempted to kill himself, Ackerly stated that there has been "a major break with reality" (p. 242). Ackerly was suggesting that the child who has already attempted suicide is in a psychotic state.

The deprivation of love increases aggressiveness in children according to Bender and Schilder (1937), and is related to the risk of suicide. These authors claimed that whenever aggression is inhibited from overt expression, it will often be turned inward. Bender and Schilder believed that the suicidal attempt also constitutes a punishment for the child's surroundings and is a method to obtain a greater amount of love. These investigators further contended that for the child, suicide either represents a reunion with a perceived or real loss of love, or an attempt to regain a deeper sense of love from his parents.

Gould (1965) described the psychodynamics of suicide in children as a gesture which is symptomatic and has multiple causes related to the physical, intellectual, and psychological levels of development. Some of those factors include: physical limitations; introjection and identification; impulsivity, ego and defenses; magical thinking and the feeling of omnipotence; the need for love and support; depression; and precipitating causes. Gould expounded on the dynamics
of introjection and identification, stressing that a child who has lost a parent or has been abandoned early in life will not experience the identification process that normally occurs in younger children. Gould cited Freud, who claimed that the suicidal person has ambivalent feelings of love and hate towards the imagined or real lost love object. Freud believed that the suicide attempt represents an effort to both preserve and destroy the loved and hated object which has been introjected (cited by Gould, 1965). According to Freud, when guilt feelings arise from the recognition of hostility towards the lost loved object, there is a turning inward of aggression which is acted out in suicide (cited by Gould, 1965).

Mosse (1974) referred to "masks of suicide" to describe behaviors where the child gets frequently injured, takes dangerous risks, or commits violent acts, in an unconscious attempt to destroy himself. The child may also attempt to commit suicide by provoking others, becoming aggressive, or attacking them -- as in the case of homicidal attempts (Mosse, 1974). Other "masks of suicide" mentioned by Mosse include: self-inflicted injuries; accident proneness; fractures, sprains, burns, and bullet wounds.

Saltzman (1976) contended that young children, especially within the 6-11 age range take their lives as a gesture of "getting back at someone, usually a parent" (1976, p. 3). Also, it is a form of calling attention to a very desperate situation such as the loss of a love object (Saltzman, 1976). Stekel is cited by Wolman (1972) who claimed that there are stronger forces involved in the suicidal
gesture of the child. Assuming that the suicidal child has a motivational need for punishment of forbidden fantasies, Stekel stated: "No one kills himself who has never wished the death of another" (cited by Wolman, 1972, p. 246).

Anger, impulsiveness, and rebellion are frequently associated with the motivation of committing suicide in children (Bakwin and Bakwin, 1957; Despert, 1952; Glaser, 1967; Jacobinzer, 1960; Shaw and Schelkun, 1965). Typically, this anger is directed toward an object of love, but is turned inward in an attempt to destroy oneself (Bakwin and Bakwin, 1957; Jacobinzer, 1960; Malmquist, 1971; Toolan, 1962; Wolman, 1972).

Oral aggressiveness has also been associated with the dynamics of suicide in children (Ackerly, 1967; Freud, 1917; Menninger, 1938). Menninger (1938) described the dynamics of suicide with "the wish to kill" (p. 24) as the expression of aggression, hate, annihilation, and revenge; "the wish to be killed" (p. 45) derived from masochistic, self-accusatory feelings of submission and self-blame; and "the wish to die" (p. 63) which is reflective of hopelessness, despair, illness and pain. Ackerly (1967) expounded on Menninger's concepts and claimed that the suicidal child seems to have combined all three wishes into his motivation of death. For example, Ackerly stated that in "the wish to kill", the child may be expressing such things as: "No one loves me, everyone hates me, I hate everybody, I'm going to kill somebody, I'm going to kill myself" (p.254). In the "wish to be killed", the child is saying: "Go ahead and kill me, you hate me, I don't want to live" (Ackerly, 1967, p. 254).
With "the wish to die", the child is saying: "If I die, I'll be happy and life will be better -- when I go to heaven, then I'll be happy" (Ackerly, 1967, p. 254).

Psychodynamic research has provided some pertinent studies which will be presented in the following section. Suicide in children is not as rare an occurrence as many would believe it to be. In figures reported as early as 1885-1896, 222 boys between the ages of 10 and 15 and 80 girls within the same age range committed suicide in Italy (Bender and Schilder, 1937). These authors quoted French statistics for the same year period (1885-1896), and reported that between the ages of 7 and 12, ninety-five suicides occurred.

Lowen (1972) claimed that actual data showed a preponderance of suicidal attempts over completed suicides by a ratio of 10:1. Although this figure is somewhat modified with children, the same concept applies as evidenced in the research by the following investigators: Ackerly (1967); Anthony (1975); Bakwin and Bakwin (1957); Gould (1965); Jacobinzer (1960); Lourie (1966); Schrut (1964); Toolan (1962).

Klagsbrun (1976) reported that while only few suicides are recorded under fourteen years of age, there is an increase in suicidal attempts and threats in this age group in children's psychiatric hospitals and clinics. Klagsbrun attributed this finding to the fact that many more medical examiners on emergency duty are becoming alerted to the difference between reported "accidents" and true suicidal attempts. Ackerly (1967) stated that a number of prevalence
studies from the various clinics across the United States report 1 to 5\% of all children admitted to child psychiatric facilities are brought with the history of suicide attempts or threats. Bakwin and Bakwin (1957) stated: "Suicidal attempts, preoccupations, and threats are frequent in children. An almost universal fantasy, especially among the younger ones is, 'If I die then my parents will feel sorry'' (p. 766). These authors contended that suicidal attempts in the majority of cases in very young children are not very serious, or at least were not meant to be so. They believe that many attempts are merely self-mutilating acts without real suicidal intentions in mind, but which are carried out as self-punishment for real or perceived wrongdoing.

Toolan (1962) indicated that suicide and suicidal attempts in children and adolescents are not rare, although the severity of the gesture is not as fully comprehended by the child as is in the adult. Kanner (1972) held the opinion that many child suicidal attempts are planned or actually set up without the real intention of death. This indicates that the child uses such a gesture frequently as a manipulative device or as a "cry for help" (Ackerly, 1967; Despert, 1952; Klagsbrun, 1976; Schecter, 1957; Schrut, 1964; Toolan, 1962).

The next section consists of several studies which have been conducted along with various case histories of children who have committed, attempted or threatened suicide. Some of these studies are truly scientific, while some of the other studies such as the case histories do not meet these criteria. Shaw and Schelkun (1965), in commenting on studies of suicide in children, stressed that they
are handicapped by two factors: the lack of uniform criteria to define and classify its different aspects; and the unreliability of much of the statistical data. The following studies include some of the more pertinent research of suicide in children which are essential in formulating hypotheses and making generalizations.

Bender and Schilder (1937) investigated a series of children with suicidal preoccupations in the children's ward at Bellevue Hospital. Sixteen of these children had either threatened or attempted suicide and were between the ages of 6 and 13. The youngest case was a 6 year old child who was receiving previous treatment for a medical disorder. Within the same time period, the child's parents died as a result of long-term illnesses. The child was severely depressed and wanted to kill himself. Frequently reported in the sixteen cases was the connection of impulsivity to the suicidal attempt or threat; the desire to punish someone; displaced anger; and depression. Bender and Schilder emphasized that the suicidal child wants to escape an unbearable situation, and a suicidal threat or attempt demonstrates the child's "unwillingness to stand a difficult situation" (p. 231). These authors contended that, because of the overwhelming nature of the situation, the child who attempts suicide usually does not expect to succeed in the act. Although Bender and Schilder's study does not truly meet the criteria of a scientific study, it does generate the hypothesis that children faced with a traumatic situation in which they want to escape may become preoccupied with suicide.
Jacobinzer (1960) conducted a study of children in N.Y.C. who were reported to the poison control center from March of 1955 to December of 1958. Limiting his research to youngsters between 8 and 19 years of age, Jacobinzer investigated the amount of unsuccessful suicidal attempts which were made with the ingestion of a noxious drug or chemical. In this three-year period, records were kept on all attempted suicides from poisoning. Jacobinzer found that there were 299 attempts in the 8-19 age group. The findings showed that more females than males attempted suicide by poisoning and that there was a preponderance of Puerto Ricans over Whites and Blacks within this population. The histories of these children revealed the following facts: 6% had made previous suicide attempts; 15% of the families involved were in the medium-income bracket, while 42% were in the low-income group; and 8% of the fathers in these families were deceased. In 29% of the cases, suicide was attempted while the mother was at home, while in over 50% of the cases, suicide was attempted without an adult family member at home. Out of the 299 cases, 67 (22%) included children between the ages of 9 and 14, while 14 (5%) of these cases included children between the ages of 9 and 12. Some of the reasons reported for attempted suicide included anger over disciplinary measures, emotional upsets, and depression (in 58, or 19% of the cases). Jacobinzer claimed that the striking feature of this study was the high ratio of suicidal attempts to successful suicides (50:1). However, only 8 successful poisoning suicides out of 299 reported attempts were recorded.
Ackerly (1967) investigated the nature of latency age children who threatened or attempted to kill themselves. There were a total of 31 children, 12 years of age and under who had previously been psychiatrically evaluated in a variety of settings. The cases were divided into two groups: one group included 24 children (18 boys and 6 girls) between the ages of 4 and 12, who had threatened to kill themselves; the second group included 7 children (4 boys and 3 girls) between the ages of 6 and 12, who had attempted to kill themselves. The difference between the groups according to Ackerly was a matter of degree of emotional disturbance. The children who threatened suicide were reacting to an acute precipitating situation of stress, while children who actually made an attempt to kill themselves showed a major break with reality and appeared more psychotic. Some of the methods used by these children in attempted suicide included hanging, strangulation, and ingestion of pills and poisonous substances. Ackerly found that latency age children become preoccupied with death and suicide when intense intrapsychic conflicts exist, and experience what Menninger described as "the wish to kill", "the wish to be killed", and "the wish to die" (cited by Ackerly, 1967, p. 254).

A prevalence study was provided by Jan-Tausch (1963), who investigated the rates of suicide among children in the New Jersey public school system over a three-year period (1960-1963). It was found that a total of forty-one children who had killed themselves showed a significant trend of disturbed interpersonal adjustment and emotional turmoil.
Stearns provided information which was somewhat contrary to the findings of Jan-Tausch, who showed that suicidal children were emotionally and socially maladjusted (cited by Bakwin and Bakwin, 1957). In the ten-year period between 1941-1950, 81 youths under 20 years of age took their lives, 18 of whom were between the ages of 11 and 14. Stearns claimed that the children in the 11-14 age bracket showed a personal history of good behavior, good standing in the community and well-developed leadership qualities, but for no apparent reason killed themselves (cited by Bakwin and Bakwin, 1957). Of the total population, one third committed suicide by hanging, another third by firearms, 15.5% by poison gas and 11.3% by ingestion of poison. Stearns believed that many of the males who died had not actually intended to kill themselves. This was inferred by Stearns because the death showed sexual-masochistic evidences (cited by Bakwin and Bakwin, 1957). For example, in some cases, the male was often found hanging nude by a pin-up of female nudes or dressed in undergarments of females. Stearns claimed that these males wanted to receive sexual enjoyment in the form ofmasochistic restraint or pain (cited by Bakwin and Bakwin, 1957).

Bakwin and Bakwin (1957) cited Mulcock, who investigated the motivations of 10-15 year-old males who had committed suicide in England and Wales during the years of 1935-1949. Mulcock saw in these males a significant trend of overwhelming stress along with the inability to handle situational problems (cited by Bakwin and Bakwin, 1957). According to Mulcock, these children came from
pathological home environments where the parents were rejecting and indifferent towards their children (cited by Bakwin and Bakwin, 1957). Another prominent feature that Mulcock noted in these males was marginal school adjustment (cited by Bakwin and Bakwin, 1957).

Schrut (1964) investigated a peculiar type of self-destructive tendency in 15 patients observed at the Los Angeles Suicide Prevention Center and private psychiatric practices. In these cases, the suicide attempt was the final in a series of various self-destructive acts. These patients had attempted suicide one or more times prior to the study. The 15 patients were divided into two groups. Group 1 included four children (2 males and 2 females) who were overall quiet, withdrawn, chronically depressed and schizoid. Group 2 included fifteen children (8 males and 7 females) who were hyperactive as infants and described by their mothers as "anxious", "difficult to handle" and "never satisfied" as infants. As older children, group 2 patients were described as generally hostile and aggressive, acting-out, delinquent and poor students. Both groups of children tended to have parents who were rejecting, indifferent, ambivalent and depressed. These children were treated at the center for a period ranging from three months to three years. Findings showed that all patients were responsive to hospitalization which provided treatment in the form of chemotherapy and psychotherapy. Follow-up of these patients was not mentioned in Schrut's account of this study.

A retrospective study of 22 suicidal patients from the Winnipeg Children's Hospital from May, 1960 through December, 1962 was
conducted by Lawler, Nakielny and Wright (1963). The purpose of the study was to investigate these children in detail as well as treat them with chemotherapy and psychotherapy. The children were between the ages of 8 and 15 years and nine children were between 8 and 12 years. The methods used in these suicide attempts included ingestion of drugs, suffocation, stabbing, and wrist slashing. Fifteen of these patients were females and seven were males. All of them had either made previous suicide attempts or had a recent history of psychiatric illness within the last six months. Three main categories of diagnosis emerged consisting of Schizophrenia, Character disorder, and Depression. Follow-up reports showed that no other suicidal attempts were made after successful treatment with chemotherapy and psychotherapy.

In a Swedish study conducted by Otto (1965), the investigation was made of children who made suicide attempts because of school problems. Between the years 1955 and 1959, 62 children (out of 1,727) with previous psychiatric histories were studied in detail. Children from 12 to 20 years of age were included, with 6% of this group consisting of 12 year olds. School problems were given as the reason for the suicide attempt in 46.7% of the cases. Such problems included anything from failure on an examination to long-term difficulties and adjustment problems. In a more recent study, Otto (1966) using the previous population of 1,727 children, had decided to observe more closely the younger age group (10-12 years of age). Of seventeen children within this range (seven boys and ten girls), 69% claimed that home and parental problems was the precipitating factor
for the suicidal attempt. Three main findings were provided by Otto's study: younger children attempt suicide; girls usually outnumber boys in this gesture; and parents and home environment play a significant role in the precipitation of the suicidal attempt.

Toolan (1962) investigated statistical data from Bellevue Hospital for the year 1960 and saw that, out of 900 admissions to the children's services, 102 of these were related to suicidal attempts and threats. Of these 102, 18 (17.6%) children were under 12 years of age and 28 (27%) were between 5 and 12, inclusively. There was one 5 year-old who had made a suicidal attempt by trying to burn himself repeatedly over a gas burner, or by pouring scalding hot water over himself. He would then repeatedly pick at his burns so that they would not heal. The child apparently had a history of self-destruction, especially in situations where he could not get his own way. Regarding the home environment of all the cases, forty-two (41%) children attempted suicide while the mother was home and 32 (31%) children attempted to kill themselves while both parents were at home. There were 23 (22%) children who had tried to take their lives in homes where the father was absent from family life for over two years and 20 (19.6%) children who tried suicide in homes where fathers had been absent for six months to a year. The figures were not significant in conditions where the mother had been absent. The diagnoses of these children varied from Schizophrenic reaction to Personality Trait Disorder. Many of the symptoms reported included restlessness, boredom, hyperactivity, truancy, acting-out, impulsivity, aggressiveness, and depression.
Mattsson, Seese and Hawkins (1969) conducted a retrospective and follow-up study of 75 suicidal children and adolescents at the child psychiatric clinic at Cleveland University Hospitals. The main purpose of the study was to investigate how many emergency referrals were received in the clinic over a two-year period that were related to suicide. These referrals were then compared to a group of non-suicidal children. Another purpose of this study was to investigate the effectiveness of the emergency consultation program in terms of service given to families with a suicidal child. A total of 170 emergencies were referred over this two-year period (July, 1963 to July, 1965) which consisted of 75 suicide attempt cases and 95 non-suicidal cases. The 75 suicidal children represented the first group which included 7% below the age of 12. Subsequently, the 95 non-suicidal children included 25% below the age of 12. Children in the first group were distributed into six groups based on suicidal motivation such as: (1) loss of love object followed by acute or prolonged grief; (2) "the bad me" markedly self-depreciating patients; (3) the final "cry for help" directed beyond the immediate family; (4) the revengeful, angry teenager; (5) the psychotic adolescents; and (6) the "suicide game". The findings showed that, over a two-year period, 75 suicidal cases constituted about 44% of the emergency referrals and Mattsson, Seese, and Hawkins (1969) believed this percentage to be somewhat representative of all child psychiatric suicidal emergencies annually.

The preceding section was designed to alert the reader to a clear picture of the prevalence of suicide in young children.
There is evidently a need for more extensive empirical research in this field with a greater emphasis on scientific methodology. However, the research cited makes it reasonable to conclude that suicide in young children is not a rare occurrence and is certainly more important an issue than was believed.

**Behavioral, Environmental, and Phenomenological formulations.**
The Behavioral viewpoint regards suicide as a deviant or inappropriate behavior when alternate forms of responding are no longer perceived by the individual. The terms "self-destructive" and "self-injurious" behavior are common in the Behavioral literature (Bandura, 1969; Lovaas, Freitag, Gold and Kassorla, 1965; Risley, 1968; Wolf, Risley, and Mees, 1964). However, these terms seem to have less drastic and terminal connotations than the term "suicide", and are found more often in the literature. One of the problems confronted when investigating this literature in relation to self-injurious or self-destructive behavior is that many cases cited are those of a schizophrenic or autistic nature. Since the scope of this paper has characterized those emotionally disturbed children of a more neurotic type, it is somewhat difficult to make generalizations. However, the principles are similar and may be interpreted on the same level.

Wolman (1972) believed that suicidal behavior in children is "self-destructive or aggressive behavior" which has consistently been positively reinforced through social means. Parents tend to overreact when they see their children engaging in self-injurious behavior and come to the rescue with such behaviors as sympathy, affection, and reassurance (Bucher and Lovaas, 1968; Lovaas, Freitag, Gold and
Kassorla, 1965). Lovaas, Freitag, Gold, and Kassorla (1965) have also found that self-injurious responses are contingent upon social reinforcement, but can be "cued off" by reinforcement of other incompatible behaviors. Teicher and Jacobs (1966) stated that children who attempt to commit suicide have previously developed patterns of aggressive reactions to insecurity-provoking situations. The control of such aggressive reactions and self-destructive patterns has also been strongly emphasized in the Behavioral literature. For example, punishment has been indicated as an adjunct to both extinction procedures and differential reinforcement (DRO) of competing response patterns (Bandura, 1969). It has been observed that reduction in self-destructive behavior was made possible with the use of brief social withdrawal (Hamilton, Stephens and Allen, 1967; Lovaas, Freitag, Gold, and Kassorla, 1965; Wolf, Risely and Mees, 1964). Conceptually, children who are suicidal and have such self-destructive tendencies can be influenced to respond alternately when such undesirable behavior is punished and desired incompatible behaviors are reinforced.

Alternate views have been provided by Environmentalists. Gould (1965) cited Bruhn, who has shown that social disorganization contributes to suicide attempts. Bruhn observed that five times as many youngsters attempted suicide in a home environment where there was an absence or a death in the family, when compared to control patients (cited by Gould, 1965). The factor of stress has also shown that children with a low tolerance for frustration or who have been subjected to persistent stress seek suicide (Shaw and Schelkun,
Tuckman and Cannon, according to Shaw and Schelkun (1965), showed that urban children who experienced high levels of stress, parental neglect, cruelty, and abandonment are potentially high suicidal risks.

An alternate view has been provided by Durkheim as cited by Stewart and Glynn (1971). Durkheim believed that when an individual commits suicide, he is not only destroying his own life, but he is severing his relationships with others (cited by Stewart and Glynn, 1971). Durkheim refuted the description of suicide as a psychological phenomenon, but considered it more in terms of a social incident related to group identity (cited by Stewart and Glynn, 1971). Three forms of suicide have been described by Durkheim: "egoistic suicide", which describes the isolated individual who commits suicide when he has felt a detachment from group belongingness; "anomic suicide", which describes the individual who commits suicide as a result of normlessness, or confusion over existing norms; and "altruistic suicide", which characterizes the person who has had a "heroic" or "self-sacrificial" motivation attached to his suicide (cited by Stewart and Glynn, 1971). It is questionable whether Durkheim's descriptions are applicable in the case of child suicide because of the complexity of his theory. However, Durkheim's concepts may have more meaning when applied to the case of the adolescent. For example, the "egoistic suicide" may represent the adolescent who has destroyed himself as a result of group and peer pressure.

Some Phenomenological viewpoints, described in an earlier portion of this paper (p. 41), may also be appropriately interpreted.
here. Martin's (1972) theory of neurosis may be applied in the case of the suicidal child who is experiencing low self-esteem, anxiety, guilt, depression, and helplessness. Self-defeating behaviors which are mentioned by Martin may also be interpreted to describe the act of suicide. Roger's (1959) model of neurosis may also be applied to the suicidal child, who in the midst of a conflict between the actual and perceived self, has developed "incongruence between self and experience" (p. 203). Threats to the child's worth and self-esteem create a state of painful anxiety where the outcome may be aversive. It appears that while the act of suicide in children may contain manipulative value, the pervasive state of overwhelming anxiety may only be reduced by self-destruction. As with the research in childhood depression, there is a greater amount of investigation in the Psychodynamic literature. Less extensive are the studies provided in the Behavioral and Phenomenological literature. Also, as with childhood depression, the psychopathology of suicide is greatly over-emphasized in terms of adult psychiatry. However, there is currently more conclusive evidence regarding the prevalence of suicide in children. As more scientific and clinical data are accumulated, perhaps the psychopathology of suicide in children will fit into a more universal framework.

The Suicidal Personality

Predisposition to Suicide

Lawler (1963) observed that children who attempted suicide were of superior intelligence. However, Lawler claimed that they frequently had long standing and unrecognized intrapsychic and interpersonal
conflicts within an environment of family psychopathology. Shaw and Schelkun (1965) saw that personality correlates of suicidal children included impulsiveness, aggressiveness, sado-masochism, and magical thinking. Lourie (1966) investigated the nature of the suicidal personality of children and saw that the majority of cases exhibited difficulties in impulse control which was encouraged by the family. Schrut (1964) saw that children who were predisposed to suicide exhibited patterns of self-destruction through such masked behaviors as accident proneness, masochism, school failure, and provocation of peers, teacher, and parents. Acting-out and aggression have also been correlated with children of the suicidal personality (Ackerly, 1967; Bakwin and Bakwin, 1957; Despert, 1952; Glaser, 1967; Jacobinzer, 1960; Mosse, 1974; Shaw and Schelkun, 1965; Toolan, 1962). Malmquist (1971) described the prototype of the suicidal child in terms of manipulative and spiteful aspects directed towards parents: "It serves my mother right if I break my leg" (p. 892). This rationale, according to Malmquist, serves the purpose of projecting blame on the parents and punishes them for the child's feelings of failure.

Bergstrand and Otto (1962) cited Mulcock, who emphasized that factors predisposing the child to suicide include: "a general lowering of mental resistance due to difficult conditions of growth and environment, lack of love, adjustment difficulties of various kinds, abnormal personality traits, mental illness or poor intelligence, a broken home, sibling conflicts, the feeling of being excluded and unwanted, school difficulties, etc." (p. 24). Gould
(1965) contended that the core factor in the formation of a suicidal personality in children is the "felt loss of love", but the actual precipitating event in a suicide attempt can be virtually anything. Gould further stressed that depression is almost always part of the suicidal personality of children and adolescents, as well as adults. Other proponents of this notion include Bakwin and Bakwin (1957), Otto (1966), Shaw and Schelkun (1965), Schrut (1964), and Toolan (1962).

Otto (1964) investigated the possibility of a presuicidal syndrome in children. In the period preceding the suicidal attempt there was a noticeable change in the behaviors of these children. Depressive and neurotic symptoms included anguish, restlessness, psychosomatic difficulties, aggressiveness, labile affect, despair, increased irritability, and social maladjustment. Otto (1964) cited Andics, who observed that a presuicidal syndrome in children was characterized by "narrowing of consciousness, increased aggressiveness and escape into fantasy" (p. 387). Paerregaard, Wall, Litman, and Ringel are cited by Otto (1964) as contending that depressive affect in children was the most conspicuous component that preceded a suicidal attempt. Shaw and Schelkun (1965) reported on depression to be a major factor in child suicide. According to Shaw and Schelkun, suicidal children frequently exhibited such behaviors as hypersensitivity, impulsivity, aggressiveness, sado-masochism, low stress tolerance, magical thinking, and suggestibility. Suggestibility refers to the child's capacity for responding to strong death wishes imposed upon him by those close to him (Shaw and Schelkun, 1965).
The Child's Concept of Death

Gould (1965) stated that children frequently attempt suicide in order to regain contact with an actual loss of a loved one. Ackerly (1967) claimed that the suicidal child has been overwhelmed with guilt and has directed hatred against himself, "with the hope that in death he will find those unfulfilled pleasures and narcissistic satisfactions denied him in reality" (p. 242). Ackerly further stated: "Thus death means for him (the child) a better and happier life, or symbolically a wish to reunite with the all-giving good mother, the state of primary narcissism . . . ." (p. 242). Ackerly contended that latency age children tend to deny the concept of death or equate it with separation, departure, or sleep. Between the ages of 5 and 9, death is perceived by the child more in terms of murder, violence, retribution, and retaliation (Ackerly, 1967). By the age of 9 and 10, according to Ackerly, the child begins to develop a causal-logical explanation for death brought about by natural processes.

Rochlin was cited by Ackerly (1967) as purporting that children around the age of three or four become more aware of the possibility of their own death. However, Rochlin claimed that because of their overwhelming fear of death, children build up defenses against this idea (cited by Ackerly, 1967). Rochlin stated that the child views death as reversible and temporary in order to cope with that reality (cited by Ackerly, 1967). According to Rochlin, heaven or hell are concepts that arise fairly early in the child's mind long before religious instruction is presented (cited by Ackerly, 1967).
Children frequently devise a pleasant fantasy to which they go after they die in order not to face the reality of death (cited by Ackerly, 1967). Despert (1952) cited Schilder and Wechsler, who commented on the child's concept of death: "It is through experienced objects that the child thinks about death as a kind of deprivation which is unbearable, but seldom as something definite and final" (p. 378).

Toolan (1962) also supported the concept that children perceive death as reversible. However, Toolan believed that this concept should be the very reason why a child would not attempt suicide. If the child has an incomplete notion of death, then he has less reason for wanting to explore it, according to Toolan.

Gould (1965) contended that the child has a very "incomplete distorted concept of death" (p. 229) and views it as a basic reversible process. He claimed that this concept is the result of several factors: intellectual development, cultural attitudes, and influence of the media. The factor of intellectual development involves the child's capacity to think in abstract, philosophic, and metaphysical terms is limited. According to Gould, this variable is not yet found in children. The second factor concerns cultural attitudes. Western culture presents death as a somewhat unrealistic occurrence to the child. Because death is generally considered "taboo", many adults protect the child from the ugliness of its reality (Gould, 1965). Gould stated that it is the adult's own anxiety about the subject that prevents him from informing the child. Media is the third factor that makes death appear unrealistic to the child (Gould,
1965). Actors are killed on T.V. and movie screens but often seen the next day on a talk show or in another movie. It is these variables that make death appear reversible and temporary to the child (Gould, 1965).

Bakwin and Bakwin (1957) contended that children are generally not concerned with their own death even though they may conceive the possibility of others' death. According to Bakwin and Bakwin, children strongly believe that they will not die. For children, death seems so far into the future that it loses its urgency. Since the child associates death with old age, its occurrence is so remote that it causes him little concern (Bakwin and Bakwin, 1957).

Bergstrand and Otto (1962) were also of the opinion that children view death as something that is reversible. Because children perceive death as less drastic, suicide may serve as a means of retaliation against the environment (Bergstrand and Otto, 1962). Further, Bakwin and Bakwin concluded that the child who attempts suicide may be manipulating others' love and attention.

Wechsler and Schilder (1934) indicated that in the child's concept of death, the idea of violence has great significance. According to Wechsler and Schilder, aggressive and sadistic attitudes play an important role in suicidal attempts in children. These investigators gave four reasons why a child might attempt suicide: (1) he is trying to escape an unbearable situation; (2) he is seeking for more love in death than life has offered him; (3) he is searching for the final sexual union with the ideal mate; and (4) he is seeking for
the final narcissistic perfection which can give eternal and un-challenged importance--the gratification of masochistic tendencies (Bender and Schilder, 1957).

Gould (1965) stated that the child's distorted concept of death can either increase or decrease the probability of a suicide attempt. Why the child's concept of death can work against the potential of suicide is explained by Gould: "One generally has to understand a concept to handle it effectively. With his inability to think much about death or understand how it occurs, he (the child) could hardly be expected to engage in behavior designed to bring about his own or anybody else's death" (p. 230-231). On the other hand, the reason why the child's concept of death can facilitate suicidal behavior, according to Gould, is because: "He (the child) is unaware of the irreversibility and finality of death, he may think of it as a way out of an unpleasant situation which might, in reality, be quite trivial; but then, his notion of death is quite trivial also" (p. 231).

Family Pathology

Lawler (1963) investigated 22 case histories of attempted suicide in children of Winnipeg Children's Hospital. From the period of May 1960 to December 1962, Lawler worked with these children and found that family relationships in the majority of cases were grossly disturbed. For example, in one case the parents were overtly sadistic; in other cases, the parents were extremely domineering; and in most cases, the parents were openly rejecting of their children. The most common disruption of home life included
such factors as parental death or desertion, alcoholic family members, severe neurosis, manic-depressive psychosis, and schizophrenia.

Ackerly (1967) found that parental separation, divorce, or death was seen in approximately one-third of the cases of 31 latency age children who either attempted or threatened to kill themselves. Most frequently, these children brought out feelings of wanting or threatening to die in the midst of an argument or quarrel with a parent.

Bergstrand and Otto (1962) conducted a study regarding suicidal attempts in 1,727 Swedish children between 10 and 21 years of age. They saw that alcoholism was a problem in one or both of the parents in 15% of the cases. Also, in 23% of the cases, the parents revealed neurotic disorders. In 44% of the cases, divorce, death of a parent, unmarried mother, or birth of a sibling were factors involved. In a later study reported by Otto (1966), the same population of children were investigated with a greater emphasis on children who were under 14 years of age. Forty-two children were under 14 years of age, while seventeen were between the ages of 10 and 12. In this group of 14 years and under, 69% of these children informed the investigators that home and parental problems were the precipitating factors for the suicidal attempt.

Klagsbrun (1976) associated children of suicidal parents to have a higher than average rate of suicide because they grow up with feelings of guilt, anger, and a sense of worthlessness. Klagsbrun referred to "survivor guilt" to describe the child who suffers on a
long-term basis after the suicide of a parent. The child goes through his life making such statements as: "What did I do to make my mother kill herself?"; or "Why did my father die while I stayed alive?" Children of suicides may kill themselves to reunite themselves with the parent who abandoned them (Klagsbrun, 1976).

Schrut (1964) investigated 19 suicidal children who were between the ages of 7 and 19 years. The majority came from families where there was either marital discord between parents, frequent abandonment by the father, severe rejection and hostility from mother, or overall parental ambivalence towards the child.

Allen and Peck (1976) claimed that many youths who commit suicide frequently struggle with parents who want them to be successful. These parents tend to overemphasize success in their children in order to compensate for their own feelings of failure, inadequacy and insecurity (Allen and Peck, 1976). They tend to see their children as an extension of their own fantasies and therefore tend to black out other kinds of communication from their children, especially those implying failure (Allen and Peck, 1976). These authors further explained that such children learn early that being a perfect projection of their parents' fantasies will help win their approval. Allen and Peck contended that, generally, many young people attempt suicide who come from a disrupted home environment with parental loss or death, divorce, and overt rejection.

In a study conducted by Peck and Litman (1975), it was seen that nearly two-thirds of a group of youngsters who had attempted suicide had been on poor terms with their families. Nearly 90% felt that
their families did not understand or appreciate them. Peck and Litman believed that a lack of communication was the most common denominator involved in the continuing chaos and unhappiness in these youngsters' lives.

Mattsson, Seese, and Hawkins (1969), investigated 75 suicidal children from the ages of 4 to 17.9 years of age. These researchers saw that 27 children were the victims of parental divorce or separation, 6 had sustained the loss of one parent, and 8 had a loss of both parents. The most common situation that appeared to precipitate a suicidal emergency was an acute conflict between the child and his parents.

Other investigators support the notion that parental psychopathology predisposes the child to suicide. Saltzman (1976) claimed that family pathology contributed to the probability of suicidal behavior of the child. Children of divorced, separated, alcoholic or depressed parents, according to Chess and Thomas (1971), are also predisposed to suicide. Bender and Schilder (1937) observed a series of case studies where suicidal children came from homes that were primarily aggressive. Bakwin and Bakwin (1957) maintained that children who make serious suicidal attempts under 10 years of age are badly treated at home and react with rebellious behavior; and Gould (1965) who contended that suicidal children came from a broken home situation where there was an absence or a death of a family member or members, or both.

The subject matter in the preceding section of the manuscript dealt with the issue of suicide in young children. It was evidenced
that the occurrence of suicide in children is becoming more and more a topic of concern and investigation in the clinical research. Typically, suicide has been thought to be rare or virtually non-existent in children. However, research studies and statistical data currently show this concept to be erroneous.

The following section was designed to review and investigate the relationship between depression and suicide in children. While the reader has already been introduced to some of the more pertinent literature concerning depression and suicide in children, further consideration will be given to their mutual relationship.
The Relationship of Suicide to Depression

Neurotically depressed children frequently have suicidal fantasies according to Fenichel (1945). Fenichel described the "love blackmailing tendency" in such children: "When I am dead my parents will regret what they have done to me and will love me again" (p. 400). Fenichel proposed the concept that three illusions are connected with the idea of suicide and melancholia: (1) the attainment of forgiveness and reconciliation; (2) a killing of the punishing superego; and (3) the reunion with the protecting superego which prevents any further losses of self-esteem.

Bakwin and Bakwin (1957) stressed that signs of clinical depression in children should be interpreted as a suicidal danger signal: "There are a few warning signs that should make the physician suspect impending suicide (in children). Most prominent is depression, often associated with insomnia, instability, and violent temper outbursts" (p. 768). Jacobinzer (1965) also warned that sudden personality changes in the child such as depressive reactions manifested by difficulty in the control of aggressive impulses may result in self-destruction. Another proponent that depression may implicate suicide was Saltzman (1976) who postulated: One signal of possible suicide in a young child is depression, an ailment psychiatry did not recognize in children until about ten years ago" (p. 3). Suicidal threats
may be made by depressed children, as well as by children with other types of reactive disorders, according to the Group for the Advancement of Psychiatry (1974). Lourie (1966) contended that depression in children is a situational as opposed to a superego phenomenon. According to Lourie, suicide can impulsively occur because the step between suicidal ideation and suicide attempt is a small one.

Jacobs (1971) cited Schecter, who claimed that "suicidal equivalents" in the form of depression can occur in children, when the motivation for suicide is viewed in terms of attack on the introjected object. Thus, the attempt to recover the love object and regain contact and gratification may be so desperate that suicide potential is increased (Jacobs, 1971). The similarity between the dynamics of depression and suicide is further provided by Gould (1965) who stressed that depression in children in either its "pure" or "disguised" form is the underlying motivation for suicide because it involves such typical depressive content as: the wish for reunion with a lost love object; retaliation for abandonment; atonement for sins; and a last "cry for help". Gould strongly emphasized that depression is almost always a part of the underlying psychodynamics of the "suicidal personality" of children, especially when they have experienced the loss of a love object. Gould stated: "Depression is one of the cardinal symptoms in the dynamics of most suicidal patients" (p. 231). According to Gould, the association of depression to suicide is well known, but the problem is more complicated in children because it tends to be masked by other behaviors rather
than occur in its pure state. Other dynamics provided by Gould regarding the relationship of suicide and depression include such concepts as feelings of worthlessness, loss of self-esteem, anger, guilt, exaggerated needs for love, the desire to punish and be punished. Gould postulated that the potential risk of suicide in a child can often be measured by the degree to which the depression manifests itself. Further, if the child is feeling anger toward a love object such as a parent, the child may develop feelings of guilt (Gould, 1965). When the child attempts suicide, he is punishing himself for those hostile feelings once directed towards his parents, while at the same time placing on them the responsibility for his death (Gould, 1965).

Several pertinent clinical studies have provided evidence that supports the relationship between suicide and depression in children. Otto (1964) investigated the presence of a presuicidal syndrome which would allow for the prediction of the "high-risk" suicidal child. Out of a sample of 248 patients who attempted suicide, 95 (38.3%) had manifested depressive behavior three months prior to the attempt. Another group of 75 (30.1%) children had revealed more neurotic-anxiety type reactions prior to the suicidal attempt. Both groups constituted 68.4% of the sample and exhibited such symptoms as anxiety, sleeplessness, psychosomatic disturbances, listlessness, forgetfulness, apathy, and feelings of despair and worthlessness.

Schrut (1964), in a study of 31 children observed at the Los Angeles Suicide Center, noted a peculiar type of self-destructive
behavior in 19 patients. They were divided into two groups: In group 1, depression was manifested by quietness, withdrawal, and schizoid behavior; in group 2, depression was manifested by acting-out behaviors, hyperactivity, anxiety, aggression, defiance and rebelliousness. In both groups, there was evidence of parental-child conflict in which the child was experiencing overwhelming guilt. The depression was further intensified by feelings of loss of love which these children had experienced as a result of parental conflict. Schrut concluded that depression was a major precipitating factor.

Lawler, Nakielny and Wright (1963), in a psychiatric assessment and management of 22 children who attempted suicide, made three consistent diagnoses: Schizophrenia, Character Disorder, and Depression. Depression was found in 13 (59%) patients in which the loss of a love object was considered the underlying cause. Lawler constructed the following paradigm:

\[ \text{Loss of love object} \rightarrow \text{Depression} \rightarrow \text{Suicidal attempt} \]

Mattsson, Seese and Hawkins (1969) investigated the presence of depression in 75 chronically disturbed children between the ages of 4 and 17.9 years. These patients were seen at the child psychiatry clinic at University Hospitals, Cleveland because they demonstrated suicidal behavior. Seven percent of the cases represented the 0-11 age group. Of 75 children, 30 (40%) had displayed signs of depression one month prior to the suicidal attempt. Those who had contact with these children, such as relatives, teachers, or friends, claimed that there was a noticeable loss of initiative and self-esteem,
deterioration of scholastic performance, withdrawal, sadness, crying spells, and decreased appetite, motor activity, and sleep. Sometimes, the depressive symptoms were manifested in masked forms by such behaviors as defiance, restlessness, boredom, truancy, and anger. These findings were consistent with Gould (1965) who saw evidence of depressive symptomatology in children who attempted suicide, and Otto (1964) who also found depression to be a presuicidal syndrome characterizing the "high-risk" suicidal child.

Shaw and Schelkun (1965) reported, after extensive research, that depression is the single-most sign observed in children who are suicidal. According to Shaw and Schelkun, the child who attempts suicide evidences a constellation of affective states which correlate with those of other suicidal children. Shaw and Schelkun contended that depression is often manifested in children by feelings of loneliness, hopelessness, and a lack of sense of belongingness. In a checklist developed by these researchers for evaluating suicidal risk in children, depression was listed as the first of twenty-five factors. Other symptomatology included such behaviors as hostility, aggression, loneliness, self-deprecation, sado-masochistic tendencies, death of a parent, low frustration tolerance and accident-proneness. Shaw and Schelkun reported that any combination of these symptoms are considered very dangerous in terms of suicide potential.

Mosse (1974) contended that the suicidal child is frequently the victim of an underlying depression. Mosse purported that an underlying depression is often masked by such symptoms as mood swings,
dizziness, insomnia, hallucinations, headaches, temper tantrums, running away from home, and violent acts. Frequently, such behaviors may result in patterns which preclude the suicide attempt. Mosse claimed that once a child has lost a loved one, signs of depression may be evident when the child says he hears that person calling him by name. According to Mosse, one might suspect the probability of suicide when the child claims that the deceased person is beckoning him to come and join him.

Despert (1952) investigated a depressive mood in relation to suicidal preoccupation and suicidal attempts. Despert, in 400 psychiatric child patients, found that out of 26 depressed children, 20% of them had attempted suicide. Toolan (1962) discussed "depressive equivalents" in a statistical study of 5-16 year old children who had made suicide attempts. With 28 (27%) of these children representing the 5-12 age group in a total sample of 102, depression was manifested in almost half of the cases. Toolan reported that these depressive symptoms had been continuously ignored by friends and relatives of these children, perhaps because of the "erroneous" concept that children do not become depressed. Toolan refuted this concept: "If we can successfully recognize the signs by which depression is manifested in younger persons we shall then be in a position to prevent many serious suicidal attempts" (p. 723).

Ackerly (1967) investigated 31 cases of latency age children who attempted or threatened to kill themselves. He contended that the subject of depression in children is essential whenever the
psychopathology of suicide is investigated. Anthony (1975) claimed that while the act of suicide is more closely related to depression in adult psychopathology, there is a much stronger relationship between attempted or threatened suicide and depression in child psychopathology. Kanner (1972) believed that when a child is depressed and lives in a fearful and gloomy environment, self-destructive thoughts tend to set in. The degree to which a child becomes depressed in such an environment strongly influences the extent to which that child becomes preoccupied with suicide (Klagsbrun, 1976). Klagsbrun (1976) emphasized that the common denominator between depression and possible suicide in children is the lack of love and support. According to Klagsbrun, if the child has been the victim of a parent suicide, he may not only feel guilty, but angered at that parent who deserted him. Terrified at having such hostile feelings, the child will direct that anger inward and possibly develop suicide ideation.

Other investigators are cited by Otto (1964) as having stressed the connection between depression and suicide in children (Paerregaard, Andics, Wall, Litman, Ringel, and Motto and Greene). Otto cited Motto and Greene, who purported that signs of psychotic or neurotic depression are significant indicators of suicide in children. Motto and Greene contended that depression is frequently the precipitating factor to the suicidal act. Wall was also cited by Otto (1964) as reporting that suicide was preventable in patients at a New York mental hospital. Wall believed that depression is a presuicidal syndrome that can be treated to help decrease suicidal risk
(cited by Otto, 1964). Wall reported the following signs of depression: feelings of guilt, self-depreciation, self-blame, severe hypochondriasis, fear of losing control and fear of hurting others and oneself (cited by Otto, 1964). Kielberg was cited by Otto (1964) who contended that depression is frequently found in connection with their child suicidal attempts.

Allen and Peck (1976) also emphasized that suicide and depression are closely related: "Anxiety, depression, confusion, and so on -- form other components of suicide risk. The more intensive and extensive the symptoms, the greater the suicide danger. Depression, in the wide variety of ways in which it is expressed, is a major factor" (p. 6).

Although the preceding information concerning the topic of the relationship between suicide and depression in children is by no means exhaustive, it is worthy of further investigation. There appears to be a more serious connection between suicide and depression in children than may have been believed. Whether depression in children predisposes the child to suicide in the future, or becomes a precipitating factor prior to a suicide attempt is debatable among investigators. The significance of evaluating suicidal behavior in terms of depressive manifestations is that it appears to contain clinical value to the diagnostician.

Conclusions Concerning the Relationship Between Suicide and Depression

To avoid the risk of repetition, these studies of suicide and depression will not be reiterated. Therefore, based on the previous
evidence cited it can be safely stated that depression appears to be predictive of suicide in children, but the extent is undetermined at this point. First of all, to make too strong a statement concerning the predictive value of depression for suicide would be beyond the scope of this manuscript in that there is the absence of this writer's own empirical study. Second of all, to state that depression is "highly" predictive of suicide risk would contain little value without a correlational study and statistical analyses of these two variables.

It is the purpose of this section to draw a general conclusion concerning the predictive value of depression to suicide based on the literature reviewed. For example, some pertinent research cited in this manuscript showed substantial evidence that when depression in children is prevalent, they become predisposed to suicide (Ackerly, 1967; Bakwin and Bakwin, 1957; Jacobinzer, 1965; Lawler, Nakielny, and Wright, 1963; Mattsson, Seese, and Hawkins, 1969; Otto, 1964; Saltzman, 1976; Schrut, 1964; Shaw and Schelkun, 1965). It can be said, that based on the literature reviewed in this paper, suicide and depression in children are significantly related. Further, depression appears to be predictive of suicide and suicide risk in children, but to what extent has not yet been empirically determined. A correlational study between the variables, suicide, and depression, is highly needed. The hypothesis to be tested may be stated as such: There is a direct relationship between depression and suicide. Nevertheless, certain important factors emerge and are summarized in the following sections.
Internal factors. It was discussed earlier in this paper that there is such an entity called "the depressed personality" (Anthony, 1975; Burks and Harrison, 1962; Cytryn and McKnew, 1972; Engel, 1962; Fast, 1963; Malmquist, 1971; Poznanski and Zrull, 1970; Sandler and Joffe, 1965; Schaffer, 1974; Seligman, 1973; Symonds, 1966). It was also seen that certain kinds of children reveal what has been referred to as "the suicidal personality" (Ackerly, 1967; Bakwin and Bakwin, 1957; Glasser, 1967; Gould, 1965; Jacobinzer, 1960; Lawler, Nakielny, and Wright, 1963; Lourie, 1966; Mosse, 1974; Otto, 1964; Shaw and Schelkun, 1965; Schrut, 1964; Toolan, 1962). It appears that many traits within the depressed and suicidal personalities overlap; thus, it is questionable whether both forms of personality should be distinguished from each other. There is evidence which implies that children who have such personalities are either predisposed to depression or suicide, or both. It could be postulated then, that a particular kind of depressive personality does increase the risk of suicide.

Research shows that children who have either committed, attempted, or threatened suicide manifest depressions that are frequently diagnosed as neurotic (Fenichel, 1945; Mosse, 1974; Motto and Greene, 1958; Otto, 1964), psychotic (Ackerly, 1967; Lawler, Nakielny, and Wright, 1963; Mattsson, Seese, and Hawkins, 1969), or "normal" reactive (Group for the Advancement of Psychiatry, 1974). As for the predictive value of depressive manifestation in the suicide risk, it can be said that all diagnoses of depression are to a certain degree
considered pathological. In essence, every form of depression in children can be appreciated to determine the risk of suicide (Gould, 1965; Jacobinzer, 1960; Lawler, Nakielny, and Wright, 1963; Otto, 1964; Shaw and Schelkun, 1965).

**External factors.** It has been observed that children raised in psychopathological environments are frequently predisposed to depression and the potential risk of suicide (Ackerly, 1967; Bakwin and Bakwin, 1957; Bergstrand and Otto, 1962; Gould, 1965; Lawler, Nakielny, and Wright, 1963; Mattsson, Seese, and Hawkins, 1969; Otto, 1966; Schrut, 1964). Other investigators who have also demonstrated that family pressure and pathology contribute to the risk of suicide in children are Bakwin and Bakwin (1957), Bender and Schilder (1937), Bergstrand and Otto (1962), Chess and Thomas (1971), Peck and Litman (1975), Saltzman (1976), and Toolan (1962).

Although the research continues to support the direct relationship between family pathology and child suicide, further investigation is needed. Specific focus would be on the dimension of depression in the child and the parent.
Summary

The purpose of this paper was to investigate the subject of suicide and depression in children within the ages of 5 and 12, inclusively. Although some of the literature dealt with children who were outside of the latency and preadolescent stages, it is hoped that those findings are generalizable.

First, the question of depression in children was investigated. Based on the literature cited, one speculation was that depression is prevalent in children. However, it was acknowledged that this hypothesis needs to be empirically tested before any conclusive evidence can be drawn.

Second, the question of suicide in children was investigated. It was shown that suicide is not as rare an occurrence in children as was believed. Yet, a greater emphasis needs to be placed on suicide in terms of child psychiatry, as opposed to adult psychiatry.

Third, the question whether or not there was a direct relationship between depression and suicide in children was investigated. Based on the literature, it appears that there is a significant relationship between these. The strength of the relationship, however, cannot be determined without specific empirical research. A further issue raised was whether depression could be used as a valid
indicator of suicidal risk. This also was a hypothesis which needed to be tested.

The intention of this paper was to create a greater awareness and convey a message of urgency regarding suicide and depression in young children. It is believed that this manuscript will serve as a guideline and source to stimulate further research with controlled studies and adequate statistical analyses.

It can be concluded that the aforementioned areas of investigation do contain value to clinical psychology and applied aspects of the field. Hopefully, this message will become increasingly emphasized, and investigators will be alerted to this underdeveloped area of child psychiatry.
Appendix: Suicide Mortality Rates by Sex, Race, and Age Groups (1900 to 1975)

Table A: 1965 to 1974

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<td></td>
<td>1973</td>
<td>10.0</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>1974</td>
<td>10.2</td>
<td>0.4</td>
</tr>
</tbody>
</table>

(Source: U.S. National Center for Health Statistics, Vital Statistics of the United States, annual (Series no. 263), 1976, 159.)

(Rates per 100,000 population. Beginning 1970, excludes deaths of non-residents of the U.S.)

Table B: 1965 to 1974

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
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<tr>
<td>F E M A L E</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>1970</td>
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<td>0.1</td>
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<td></td>
<td>1973</td>
<td>7.0</td>
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<td></td>
<td>1974</td>
<td>7.1</td>
<td>0.2</td>
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<td>1965</td>
<td>2.5</td>
<td>0.1</td>
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<td>0.2</td>
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<tr>
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<td>1973</td>
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<td>0.1</td>
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<tr>
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<td>1974</td>
<td>3.0</td>
<td>0.2</td>
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</table>

(Source: U.S. National Center for Health Statistics, Vital Statistics of the United States, annual (Series no. 263), 1976, 159.)

(Rates per 100,000 population. Beginning 1970, excludes deaths of non-residents of the U.S.)
Table C: 1926 to 1929

<table>
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<th>Year</th>
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<td>53</td>
</tr>
<tr>
<td>1928</td>
<td>36</td>
</tr>
<tr>
<td>1929</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>162*</td>
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</table>


*106 Males 56 Females 153 Whites, 9 Negro

Table D: Methods of self-destruction 1926 to 1929

<table>
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<tr>
<th>Method</th>
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<tbody>
<tr>
<td>Firearms</td>
<td>79</td>
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<tr>
<td>Hanging/Strangulation</td>
<td>44</td>
</tr>
<tr>
<td>Corrosive Substances</td>
<td>14</td>
</tr>
<tr>
<td>Drowning</td>
<td>8</td>
</tr>
<tr>
<td>Poisonous Gas</td>
<td>5</td>
</tr>
<tr>
<td>Cutting/Piercing</td>
<td>2</td>
</tr>
<tr>
<td>Crushing</td>
<td>1</td>
</tr>
<tr>
<td>&quot;Other Means&quot;</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
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Table E: 1942 to 1946

<table>
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<th>Year</th>
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<tbody>
<tr>
<td>1942</td>
<td>55</td>
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<tr>
<td>1943</td>
<td>59</td>
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<tr>
<td>1944</td>
<td>46</td>
</tr>
<tr>
<td>1945</td>
<td>50</td>
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<tr>
<td>1946</td>
<td>57</td>
</tr>
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</table>

Table F: 1900 to 1947

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
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<tr>
<td>1900</td>
<td>7</td>
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<tr>
<td>1910</td>
<td>30</td>
</tr>
<tr>
<td>1915</td>
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<td>1920</td>
<td>36</td>
</tr>
<tr>
<td>1925</td>
<td>47</td>
</tr>
<tr>
<td>1930</td>
<td>50</td>
</tr>
<tr>
<td>1935</td>
<td>57</td>
</tr>
<tr>
<td>1938</td>
<td>39</td>
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<td>49*</td>
</tr>
<tr>
<td>1941</td>
<td>45</td>
</tr>
<tr>
<td>1942</td>
<td>55</td>
</tr>
<tr>
<td>1943</td>
<td>59</td>
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<tr>
<td>1944</td>
<td>46</td>
</tr>
<tr>
<td>1945</td>
<td>50</td>
</tr>
<tr>
<td>1947</td>
<td>60**</td>
</tr>
</tbody>
</table>

Table G: 1947

<table>
<thead>
<tr>
<th>Suicide Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1947</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
</tbody>
</table>

(Source: Desperr, L. Suicide and depression in children. Nervous Child, 1952, 9, 378.)

*42 Males 7 Females 43 Whites, 5 Negro, 1 Other

Sex ratio: Male to Female: 6:1
Race ratio: Whites to all Others: 6.14:1

**52 Males 8 Females 54 Whites, 5 Negro, 1 Other
Table H: 1972 to 1973

<table>
<thead>
<tr>
<th>Year</th>
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</tr>
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<tbody>
<tr>
<td>1972</td>
<td>0.10 (120)</td>
</tr>
<tr>
<td>1973</td>
<td>0.40 (156)</td>
</tr>
</tbody>
</table>


(Based on a 10% sample of deaths. Rates per 100,000 population in specified group)

Table I: 1974 to 1975

<table>
<thead>
<tr>
<th>Year</th>
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<tbody>
<tr>
<td>1974</td>
<td>0.40 (188)</td>
</tr>
<tr>
<td>1975</td>
<td>0.20 (170)</td>
</tr>
</tbody>
</table>


(Based on a 10% sample of deaths. Rates per 100,000 population in specified group)

Table J: 1968

<table>
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<tr>
<th>1968</th>
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<th>10-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
<td>95</td>
</tr>
<tr>
<td>Female</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Female</td>
<td>-</td>
<td>17</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>1968</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>-</td>
<td>4</td>
</tr>
</tbody>
</table>

Table K: 1969

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>SUICIDE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Male: 4</td>
<td>Female: 1</td>
</tr>
<tr>
<td>White</td>
<td>Male: 3</td>
<td>Female: -</td>
</tr>
<tr>
<td>Negro</td>
<td>Male: 1</td>
<td>Female: 1</td>
</tr>
<tr>
<td>Other Races</td>
<td>Male: -</td>
<td>Female: -</td>
</tr>
</tbody>
</table>

|                          |           |             |
| **SUICIDE FROM POISONING BY SOLID OR LIQUID SUBSTANCE** |           |             |
| Total                    | Male: -   | Female: 8   |
| White                    | Male: -   | Female: 8   |
| Negro                    | Male: -   | Female: -   |
| Other Races              | Male: -   | Female: -   |

|                          |           |             |
| **SUICIDE FROM POISONING BY GASES** |           |             |
| Total                    | Male: -   | Female: -   |
| White                    | Male: -   | Female: -   |
| Negro                    | Male: -   | Female: -   |
| Other Races              | Male: -   | Female: -   |

|                          |           |             |
| **SUICIDE BY HANGING, STRANGULATION, AND SUFIOCATION** |           |             |
| Total                    | Male: 3   | Female: 7   |
| White                    | Male: 3   | Female: 5   |
| Negro                    | Male: -   | Female: 2   |
| Other Races              | Male: -   | Female: -   |
(Table K continued)

<table>
<thead>
<tr>
<th></th>
<th>5-9 years</th>
<th>10-14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUICIDE BY FIREARM AND EXPLOSIVE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total.</td>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>-</td>
</tr>
<tr>
<td>White.</td>
<td>Male</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>-</td>
</tr>
<tr>
<td>Negro.</td>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>-</td>
</tr>
<tr>
<td>Other Races.</td>
<td>Male</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th></th>
<th>5-9 years</th>
<th>10-14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUICIDE BY ALL OTHER MEANS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total.</td>
<td>Male</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td>White.</td>
<td>Male</td>
<td>-</td>
</tr>
<tr>
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<td>Female</td>
<td>-</td>
</tr>
<tr>
<td>Negro.</td>
<td>Male</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female</td>
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</tr>
<tr>
<td>Other Races.</td>
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<td>-</td>
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### Table L: 1970

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<tr>
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<tr>
<td></td>
<td>Female -</td>
<td>6</td>
</tr>
<tr>
<td>Other Races</td>
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<td>1</td>
</tr>
<tr>
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<td>Female -</td>
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<table>
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<th></th>
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<tr>
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<td>Female -</td>
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<tr>
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<tr>
<td></td>
<td>Female -</td>
<td></td>
</tr>
<tr>
<td>Other Races</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Female -</td>
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<table>
<thead>
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<th><strong>SUICIDE FROM POISONING BY GASES</strong></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
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</tr>
<tr>
<td>White</td>
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<td>Female -</td>
<td>2</td>
</tr>
<tr>
<td>Negro</td>
<td>Male  -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female -</td>
<td></td>
</tr>
<tr>
<td>Other Races</td>
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<td>Female -</td>
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<table>
<thead>
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<th><strong>SUICIDE BY HANGING, STRANGULATION, AND SUFLECATION</strong></th>
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<tbody>
<tr>
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<td>8</td>
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<tr>
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<td>46</td>
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<td>8</td>
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<tr>
<td>Negro</td>
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</tr>
<tr>
<td></td>
<td>Female -</td>
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</tr>
<tr>
<td>Other Races</td>
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<td></td>
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### SUICIDE BY FIREARM AND EXPLOSIVE

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<tr>
<td>Other Races</td>
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<tr>
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</tr>
<tr>
<td>Female</td>
<td>-</td>
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</table>

### SUICIDE BY ALL OTHER MEANS

<table>
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</tr>
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<td>4</td>
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<tr>
<td>Female</td>
<td>-</td>
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</tr>
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<tr>
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<tr>
<td>Female</td>
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</tr>
<tr>
<td>Negro</td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Female</td>
<td>-</td>
<td>-</td>
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<td>Male</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
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### Table M: 1971

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</tr>
<tr>
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</tr>
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<td>3</td>
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<table>
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<th><strong>SUICIDE FROM POISONING BY SOLID OR LIQUID SUBSTANCE</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
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<td>3</td>
</tr>
<tr>
<td></td>
<td>Female -</td>
<td>12</td>
</tr>
<tr>
<td>White</td>
<td>Male -</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female -</td>
<td>8</td>
</tr>
<tr>
<td>Negro</td>
<td>Male -</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female -</td>
<td>1</td>
</tr>
<tr>
<td>Other Races</td>
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<td>-</td>
</tr>
<tr>
<td></td>
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<td>3</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SUICIDE FROM POISONING BY GASES</strong></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Male -</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female -</td>
<td>1</td>
</tr>
<tr>
<td>White</td>
<td>Male -</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female -</td>
<td>1</td>
</tr>
<tr>
<td>Negro</td>
<td>Male -</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female -</td>
<td>-</td>
</tr>
<tr>
<td>Other Races</td>
<td>Male -</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Female -</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SUICIDE BY HANGING, STRANGULATION, AND SUFFOCATION</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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| **SUICIDE BY ALL OTHER MEANS** |           |             |
| Total . . . .  | Male -    | 2           |
|                | Female -  | 1           |
| White . . . .  | Male -    | 1           |
|                | Female -  | 1           |
| Negro . . . .  | Male -    | -           |
|                | Female -  | -           |
| Other Races . .| Male -    | -           |
|                | Female -  | -           |

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| **SUICIDE BY ALL OTHER MEANS** |           |             |
| Total          | -         | -           |
| Male           | -         | -           |
| Female         | -         | 6           |
| White          | -         | -           |
| Male           | -         | -           |
| Female         | -         | 4           |
| Negro          | -         | -           |
| Male           | -         | -           |
| Female         | -         | 2           |
| Other Races    | -         | -           |
| Male           | -         | -           |
| Female         | -         | -           |

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References


Jan-Tausch, J. Suicide of children 1960-63, New Jersey public school studies (Bulletin put out by the state of New Jersey Dept. of Education), P. 10.


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