The Immediate Management of Suicide Attempts in Children and Adolescents: Psychologic Aspects

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Adolescent suicide is steadily on the increase. Many attempters have previously consulted a physician, but have concealed their suicidal intent. When the attempt is made the family doctor is often the first physician contacted.

In children under 12 years of age, the population at risk for suicide includes those who feel abandoned because of neglect, child abuse, or bereavement. The early adolescent may suicide by misadventure. Adolescents at risk include those who experience rage associated with feelings of utter helplessness and hopelessness and those who use self-destructive behavior to manipulate other people in the expectation that these other people will gratify their wishes.

To ensure adequate medical and psychologic care, the physician should hospitalize the suicide attempter. Future suicide attempts are less likely if the physician can elicit the adolescent's awareness of his anger, diminish the child's self-contempt, help him to explore nondestructive solutions to his problems, and increase his awareness that his death by suicide would cause irreparable emotional damage to his family. The initial management provides the data required for formulation of an aftercare plan that the physician may coordinate and monitor.

Death, by suicide, of a child or adolescent is the essence of tragedy. Yet, adolescent suicide is steadily on the increase. The death rate from suicide among teenagers 15 through 19 years of age in the United States increased from 3.6 per 100,000 in 1960 to 5.9 per 100,000 in 1970.[1] These statistics underestimate the true incidence of suicide because of under-reporting. Suicide prevention centers have not reduced the suicide rate. Adolescents attempting suicide rarely call such centers. Neither do they consult psychiatrists. Most attempters, in the months before the suicide attempt, have consulted a physician concerning functional complaints. However, they conceal their suicidal ideation or intent. Frequently, only siblings or friends know of the youngster's inner turmoil and self-destructive potential.

When the suicide attempt occurs, the pediatrician or family doctor is the first physician contacted. He must rapidly assess the medical status of the patient and institute life-saving measures. Additionally, in order to plan specific medical care and to prevent future attempts, he must ascertain details of the self-destructive episode. This may be difficult because the child and parents, not fully comprehending the risk to life, may provide inaccurate or incomplete data. Their feelings of fear, anger, shame, or guilt evoke attitudes in the physician which may become obstacles to objectivity in his care of the patient.

It is necessary to consider what motivates self-destructive behavior in children and adolescents in order to identify the population at risk and to assess risk in the individual patient.

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The Young Child

Completed suicide is extremely uncommon before the age of 12.[2] This may be explained in part by the young child's inability to develop an effective plan for his own destruction, by the relative unavailability of means, or by the adult supervision often afforded children of this age. When the young child does commit suicide, it is commonly an impulsive act occurring in his own home while unsupervised.[3] The act may be undertaken for various reasons but is usually associated with unrealistic expectations.

The child of eight years of age or younger may not comprehend the permanence and irreversibility of death. He may consider death a temporary absence, perhaps easily remedied by adults whom he considers all-powerful. Similarly, he may not understand that heaven is not like another city on earth where there is relative ease of transit back and forth. Rather, he may regard heaven as a temporary dwelling place where all wishes are gratified, frustrations are non-existent, or some loved person, lost to him through death, may be rejoined.

The population at risk in this age

group includes children who feel lonely and abandoned because of neglect, abuse, or bereavement. While they seldom achieve death, their ruminations, based on inadequate grasp of reality, increase the risk when they are older.

The Preadolescent and Early Adolescent

While loneliness and unrealistic thinking may cause self-destructive behavior in young children, anger primarily motivates older children and adolescents to suicidal behavior. Nevertheless, a preadolescent or early adolescent may die by misadventure.

Suicide by Misadventure

The child is typically a bright, sensitive boy with a tendency toward introspection. A situation arises in which some action on his part passes the threshold of irritability of both parents who respond with disparagement or punishment. He withdraws to nurse his grudges and to indulge in fantasy. He imagines himself the protagonist in a story in which the main character is exposed to injury or death. If, by good fortune, he joins a companion in playing out the drama, he is sustained by the friendship of his companion and the plot may be modified by the friend or by discrepancies with reality. However, if the child remains alone, absorbed in acting out his fantasy, he may unintentionally expose himself to injury or death. This is not a child who has repetitiously manipulated the sympathies of others to gain his own wishes. Nor is he responding to bad parenting. Rather, he is the victim of a miscalculation of the line between inner imagination and outer reality, a miscalculation that takes his life.

Data that suicide by misadventure does occur are derived from discussions with young people, medical students, and residents, who as young boys experienced a "brush with death" in just these circumstances. Admittedly, the child's fantasy contains themes of anger and revenge on his frustrating parents. Nevertheless, it is a temporary, childish game of pretend which, when played out, may end tragically in unintentional and unpreventable death.

The Adolescent

Other instances of suicidal behavior in early adolescents follow the pattern common to older adolescents wherein the suicidal act invariably contains two mingled components. One is rage associated with a feeling of utter helplessness and hopelessness. The other is a manipulation of the concern and guilt of significant other persons in the expectation that they will respond by gratifying the wishes of the adolescent. Before considering assessment of the relative strength of each component, the population at risk should be described.

Adolescents at Risk for Suicide

Teicher[4] has studied hundreds of 13 to 18-year-old patients who made suicide attempts. Most had taken pills. The following findings emerged. In almost every instance, the adolescent had had multiple separations from his parents during the first three years of his life. All felt there was currently no real communication or emotional ties with their families. Sixty-three percent had made previous suicide attempts and 25 percent had a parent who had attempted suicide. In 80 percent of the families, one or both natural parents were absent through divorce, separation, or death. Nearly two thirds of the youngsters reported that a family member had suffered a serious illness in the two-year period before the suicide attempt. Finally, 85 percent of these adolescents had functional complaints of headache, stomachache, or general malaise.

Progression to the Suicide Attempt

Teicher noted that the attempted suicide was not an impulsive act but was a deliberate decision reached by an adolescent only after alternative solutions to his problems had failed. The adolescent had gone through a three-phase progression to the suicide attempt. The first phase consisted of a long-standing series of behavioral problems, gradually increasing in severity and associated with growing dissension within the family. The escalation phase coincided with the onset of adolescence, ushering in the adolescent's increasing demands for autonomy that provoked parental efforts to restrict his liberty. In the final phase the adolescent, alienated from friends and parents, in part because of his own behavior, desperately latches on to someone – the boy to a girl, the girl to a boy. The very intensity of this relationship contributes to its breakup which, in turn, triggers a suicidal act that had been contemplated earlier.

Common precipitating causes of suicidal acts include rupture of an intense relationship with a peer, restriction of liberty such as incarceration, prohibition of social participation with friends of his own choosing, or an event that lowers his self-esteem, such as expulsion from school or failure to make the team or to be invited to a party.[2,4,5]

To reiterate, self-destructive behavior is rooted in anger and expresses both misery and manipulation. The relative strength of each component may be seen in the following case histories.

Patterns of Suicide

Suicide Motivated by Despair

Case 1. – Six weeks before hospital admission a 16-year-old girl had taken an overdose of aspirin after terminating a one-year relationship with her boyfriend. After recovery from the overdose she had her shoulder-length hair cut short in the hope of winning back her boyfriend. However, she disliked her new hair style and secluded herself in her room, refusing to eat. She welcomed hospitalization as an opportunity to further seclude herself from her associates until her hair grew longer.

At 12 years of age, she had had symptoms of food refusal, loss of weight, pursuit of thinness, preoccupation with calories and reduction diets, and temper outbursts. Furthermore, she had a history of episodes of food refusal in early childhood, separation anxiety on starting to school, rivalry with a younger sister, and harsh physical punishment from her parents, each of whom as children had suffered severe physical abuse from their mothers. With treatment, she regained

weight and returned to good academic performance at school. However, she remained obsessively preoccupied with cleanliness of her body and with the color, length, and curliness of her hair.

After several months in the hospital, she demanded that her parents arrange to have her now longer hair straightened. Additionally, she insisted on surgical repair of a nonexistent deformity of her nose. Her anger mounted as her demands for surgical alteration of her appearance went unmet. She refused to discuss alternatives. In this context and immediately after being notified that her request for a home visit had been approved, she went for a walk. The engineer of an approaching train noted the girl walking beside the tracks and sounded his whistle. After he had blown the whistle several times, she abruptly turned and walked toward the slowing train. Just before impact, she knelt down placing her head on one rail. Instantaneous death was due to multiple fractures of the head and cervical spine and subarachnoid and intraventricular hemorrhage.

Suicide Motivated by Manipulation

Case 2. – A 21-year-old man died of renal failure due to carbon monoxide poisoning after being found unconscious in a closed garage where a car engine was running. When found, a telephone cord was wrapped tightly around his shoulder, suggesting that he was attempting to call someone when he lost consciousness. A few weeks earlier, he had been arrested for theft and formal charges were pending. Because of this, his girlfriend had rejected him.

This patient, since 14 years of age, had been intermittently under the jurisdiction of the juvenile justice system because of a nearly continuous series of property offenses. His life conformed to a persistent pattern: theft, temporary detention, suicidal threat or act, hospitalization, cooperation with hospital staff for 24 hours (followed by adamant refusal to abide by rules or to participate in treatment), and elopement from the hospital. After a few days or weeks, he would begin the process anew.

Welfare records document that this patient and his seven younger half siblings had been victims of child abuse at the hands of his stepfather. As a boy of 16, the patient confided to a counselor that a maternal aunt had taught him by word and deed how to simulate a suicidal act without causing significant harm to himself.

During the five years preceding his death, he was evaluated by five separate psychiatrists after suicidal acts, listed in chronological order: superficial cutting of wrists, self-inflicted amputation of the tip of his finger, sitting in a car that he had set aflame, and two episodes of attempting hanging. On each occasion, authorities hospitalized him and each time he refused treatment and eloped.

Without doubt, restriction of his liberty was unbearable to this boy. He learned that self-destructive behavior invariably resulted in opportunity to escape custody. Gradually his threats or acts were less effective in ensuring immediate hospitalization, causing him to utilize increasingly reckless methods to gain his objectives. On the final occasion, he miscalculated in that another garage employee failed to report to work, and presumably the victim was unable to complete an intended phone call.

The Suicidal Schizophrenic Adolescent

Suicide attempts in adults are significantly associated with primary affective disorders and alcoholism, but in teenagers they cut across diagnostic lines.[6] With one exception, diagnosis is of little help in assessing risk in an individual adolescent. The exception is the schizophrenic youngster. This patient often communicates suicidal preoccupation, but an overt act may be the first evidence of an emerging suicidal intent. His unpredictable attempt on his life may succeed because his capacity to dissociate pain and anxiety permits him to destroy himself with equanimity. One such adolescent deeply slashed both wrists and was discovered quietly watching her blood and life ebbing away.

Treatment

Hospitalization

When hospital facilities are available and adequate, the physician should advise hospitalization in a medical setting for an adolescent who attempts suicide. Often initial history is unreliable concerning the type, amount, or source of the poison ingested or the weapons utilized. The need to monitor the vital signs and behavior of the patient overrides the family's wish to avoid for themselves or for their child anticipated stigma or gossip. Hospitalization interrupts escalating tension that could precipitate further self-destructive behavior. When the patient is hospitalized, the physician can obtain data essential to discerning the conflicts and circumstances that preceded the act of self-injury. A suicide attempt is intended to end one's life. A suicidal gesture is a means by which a person communicates distress. Generally, the more planned the act or the more lethal the means, the more definite the intention to die.

Interview

When the patient is medically stable, he should be asked to describe the event that precipitated his attempt. Whether it be a recent rupture of an important interpersonal relationship, a disciplinary crisis, or a situation that caused diminished self-esteem or loss of liberty, details of the precipitating event provide clues to the sources and targets of his resentment.

Then the physician and patient may turn to exploration of the patient's earlier history. The patient's self-esteem may be elevated if together they can demonstrate that earlier unfortunate experiences caused the precipitating event to be more intolerable for the patient than it might be for another person. A patient's self-contempt is diminished when he comprehends that the intense anger that overwhelmed him was understandable in the circumstances, even though the self-destructive expression of resentment was dangerous and maladaptive. In this manner, the physician accepts the troubled adolescent and invites him to explore non-destructive solutions to his unique problems.

Only after the patient senses the physician's regard for his dilemma can the two progress to discussion that will illuminate the patient's characteristic methods of coping with his own anger

and that of others. Education in two areas must follow. Since people can contain only a limited amount of resentment without hazarding explosive outbursts, the adolescent must learn to express anger. However, expression must occur in channels that do not harm others or himself. The patient must learn to anticipate realistically the possible consequences of verbalizing his feelings. Taking cognizance of possible penalties he may elect to be outspoken in some situations, restrained in others.

To this point of treatment, acceptance and understanding have prevailed. However, the patient should understand that he has placed others in an untenable position. Not infrequently the patient has burdened a friend or sibling with knowledge of his suicidal intent but has sworn this person to secrecy, saying the confidant is the last person he can trust. The confidant is then trapped between unwilling participation in the patient's suicide or betrayal of trust. The patient may be asked to imagine how that person might feel. Commonly the patient will recognize that he has unwittingly aroused in another his own feelings of helplessness and hopelessness. The physician pursues this theme, asking the patient to imagine and describe in detail how his parents or others might feel now and in the future if he had succeeded in killing himself. The patient may be told that parents never completely recover from the misery of a child's death by suicide. Few adolescents are so intent on revenge toward parents that they can discuss these consequences for the parents and not derive some barrier against suicidal actions in the future.

Some would question the advisability of measures that increase guilt in an already despairing patient.[7] Yet, when physicians (or family) respond only to the "cry for help" component, thus failing to focus on either the manipulative aspects of suicidal behavior or the patient's responsibility for causing anguish in others, the patient is encouraged to repeat suicidal maneuvers. This pattern, once established, may lead to inadvertent death.

This structured but flexible interview format may be completed in one session or it may be utilized piecemeal over several sessions. A less directive approach is theoretically better but requires longer hospitalization and risks premature termination of contact with the physician, which is common with highly mobile adolescents.

Other Measures

Medication should be prescribed for the hospitalized patient if clearly indicated for treatment of a psychotic disorder or for relief of severe anxiety or depression. It seems unwise to use chemotherapy for outpatients because many do not keep appointments for necessary ongoing medical monitoring.

The distraught parents of a child who attempts suicide require the physician's compassionate concern. They may seek help for their own emotional disturbance or advice regarding family interpersonal relationships. Whatever help is sought, recommended, or implemented, the physician should avoid fostering in the patient unrealistic expectations that change in the parents will be sufficiently prompt or extensive to be of immediate help to the patient.

It is almost impossible to prevent the suicide of a determined patient. Adequate means are always found. Therefore, emphasis has been placed on reduction of his self-hatred so that determination lessens.[8] Nevertheless, prior to the patient's release from the hospital, the physician should instruct the parents to remove lethal weapons from the home, at least temporarily. For practical purposes there should not be ready access to guns, medicines, and poisons.

Most authorities recommend that the physician offer himself as a lifeline, a person the patient may call in an emergency. However, this is but a contingency plan, not the whole aftercare plan. The physician, with the patient's concent, should arrange changes in the patient's life which facilitate his gradual development of self-esteem through social participation and development of gratifying interpersonal relationships with others. A school nurse, counselor, or staff member of an agency working with young people is in the best position to keep tab on the patient, to offer practical help in school or recreational activities, to talk with him briefly but frequently, and to report the degree of progress to the physician.

Summary

When a child or adolescent attempts suicide, the pediatrician or family doctor is the first physician contacted. He must undertake the immediate care of the patient. He may assume responsibility for continued care in those instances where his knowledge of and rapport with the patient and his family permit the achievement of the treatment objective of prevention of future self-destructive acts. Psychiatric consultation should be obtained in those cases where the patient has attempted suicide more than once, where the physician cannot elicit sufficient data to accurately assess the patient's intent, or where the physician suspects an underlying psychiatric disorder such as depression or schizophrenia.

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