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## A Grounded Theory of Suicidality in Children Ten and Younger

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# **A GROUNDED THEORY OF SUICIDALITY IN CHILDREN TEN AND YOUNGER**

by

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Old Dominion University in Partial Fulfillment of the  
Requirements for the Degree of

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COUNSELING

OLD DOMINION UNIVERSITY  
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## **ABSTRACT**

### **A GROUNDED THEORY OF SUICIDALITY IN CHILDREN TEN AND YOUNGER**

Katherine Angela Heimsch  
Old Dominion University, 2014  
Director: Dr. Danica G. Hays

Once every two days in the United States, a child aged 5 to 14 years old dies by suicide (World Health Organization, 2010). When viewed on a spectrum that includes suicidal ideation, verbalizations, behaviors, and attempts, the problem of youth suicidality is actually far greater than the numbers of completed suicides suggest (Cheng, Tao, Riley, Kann, Ye, Tian...Hu, 2009). This study examined suicidality in children ages 10 and younger, and included the characteristics of suicidal children, factors that influence childhood suicidality, and treatment implications. The researcher conducted 12 semi-structured qualitative interviews with experienced treatment providers and performed a content analysis on 22 treatment charts of children identified as being suicidal in order to construct a grounded theory on childhood suicidality. This study found a core category of childhood suicidality, which resulted in 4 axial codes related to the spectrum suicidality present in children 10 and younger, including: suicidal ideation, verbalization, behaviors, and attempts. Through 21 open and 6 focused codes, it was also shown that suicidal children present with a range of behavioral and emotional disruption. A total of 6 axial codes interpreted causal conditions of childhood suicidality, including: abuse & neglect, separation from a primary caregiver, other trauma & stressors, negative familial influences, mental illness, and physical illness. Treatment implications were also found, and included 1 axial code of psychiatric interventions, as well as a researcher-developed theoretical code the primary researcher has labeled The RESCUE Model for Childhood

Suicidality, which provides a framework for treatment that teachers, counselors, parents and other caregivers can use when they encounter suicidal children 10 and younger.

Finally, barriers to the effective treatment of childhood suicidality were also discussed as a mediating factor to the success of treatment interventions.

*Keywords:* children, suicidality, treatment

This thesis is dedicated to the suicidal children who have not yet been identified.  
I promise to keep working for you.

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## CHAPTER ONE

### INTRODUCTION

#### **Statement of the Problem**

*Suicide* can be defined as “self-directed injurious behavior with any intent to die as a result of the behavior” (Centers for Disease Control and Prevention [CDC], 2012a). Suicide is the tenth leading cause of death for all age groups in the United States, and the third leading cause of death for those 15-24 years old (CDC, 2012b). In 2010 alone, the CDC recorded 38,364 total suicides in the United States, or approximately 105 deaths by suicide per day (2012b). Although much less discussed in popular culture, less researched by clinicians and educators, and less statistically prevalent in terms of confirmed death rates, suicide (and related behaviors and thoughts) can and does affect even very young children. This research study focused on children 10 years old and younger who experienced suicidality.

Today, researchers recognize that suicidality, viewed on a spectrum from ideation, to behaviors, attempts, and completions, is an exponentially significant problem and “public health burden” (Crosby, Han, Ortega, Parks, & Gfroerer, 2011). The scientific community has noted for decades how children can experience suicidal ideation and behaviors as early as preschool age (e.g., Rosenthal & Rosenthal, 1984; Shamoo & Patros, 1997; Skala, Kapusta, Sciaff, Unseld, Erfurth, Lesch, ...& Akiskal, 2012). Every year in the United States, approximately five children age 9 years and younger have confirmed deaths by suicide (a total of 57 from 1999 to 2010, CDC, 2013), and dozens more are likely undetected or deemed “accidents” (Mishara, 1999). When combined with the estimations that adolescents attempt 50-100 times more frequently than they complete

suicide (Cheng, Tao, Riley, Kann, Ye, Tian, ...& Hu, 2009), and 15-24 year olds attempt 100-200 times more frequently than they complete (CDC, 2012b), the prevalence of childhood suicidality becomes a much greater concern when viewed as a lifespan issue. If the same trends of adolescents are congruent with younger children, this implies that 250 to 1,000 children are likely to attempt suicide every year, thousands more will engage in suicidal behaviors or make plans to injure themselves, and likely tens of thousands will experience suicidal ideation. Davis (2004) stated, "Statistics indicate that the rate of suicide among children, even those under the age of 10, may be grossly underestimated" (p. 211).

Unfortunately, adults seem to be critically unaware of this phenomenon, and are generally unprepared with knowledge on how to manage suicidality in young people. Orbach (1988) explained a common adult response to childhood suicidality: "For many reasons, most of them understandable, adults prefer to believe that children do not commit suicide. It seems inconceivable that children could become so desperate and suffer so much at their young age that they would choose death over life. Guilt and anxiety make us blind to the truth, even when it cries out to us" (p. 23). As suicide remains the third leading cause of death for children ages 5-14 years old (World Health Organization [WHO], 2010), it is crucial for parents, health care providers, counselors, schools, and communities to become aware of the varying presentations of childhood suicidality, those children's specific needs, and treatments for managing suicidal ideation that could prevent a child's injury or death. This research study examined the factors associated with children who have thoughts and actions associated with suicide, and will provide insight as to how to best treat this underserved population. Understanding

suicidality in children may not only save their lives, but can also provide information about the progression of psychological and environmental variables that are associated with suicidality in adolescence and adulthood.

### **Rationale for the Study**

The rate of completed suicides in teens increases dramatically in pre-adolescence, adolescence, and young adulthood (WHO, 2013). While there were 57 recorded deaths in the 0-9 age range from 1999 to 2010, there were 3,008 deaths in the 10-14 age range, 19,128 in the 15 to 19 age range, and 30,862 in the 20 to 24 age range (WHO, 2013). It seems that elementary school would be a critical time to intervene and educate children about the risks of suicide and to stress prevention. For example, Washington State's Health Youth Survey showed that 15.8% of 6<sup>th</sup> graders had "seriously thought about killing themselves" (Youth Suicide Prevention Program [YSSP], 2011), meaning that middle school interventions may already be late. However, most prevention strategies, if they even exist within a school system, are aimed at teenagers at the high school level and tend to be only minimal interventions due to school personnel unpreparedness, lack of training in intervening with at-risk youth, and low school system buy-in (Walsh, Hooven, & Kronick, 2013). The "Riding the Waves" curriculum is one exception, as it also targets elementary school children (YSSP, 2011), but is not yet mandatory programming and is only available for purchase.

The problem seems to be that the general public, educators, and even suicide researchers are unaware or under-aware of the risks to children 10 and younger. Although formal research on children's suicidality began as early as 1885 by Durand-Fardel, and was studied by psychoanalyst greats such as Freud and Adler (Pfeffer, 1986),

current research does not differentiate significantly between children and adolescents' suicidality, although there may be significant differences in presentation and needs (Ben-Yehuda, Aviram, Govezenski, Nitzan, Levkovitz, & Bloch, 2012). It is the rationale of this study to raise awareness among adults about childhood suicidality and to better understand the risk and protective factors, symptomatology, common methods of children's suicidal behaviors, assessment strategies, treatments, and interventions.

Although it may seem most efficient to interview children themselves to gain a phenomenological understanding of suicidality, there are often barriers to this research method using child subjects. Some of these barriers include: accessing suicidal or mentally ill children, gaining assent and parental consent to participate in research, possibly interrupting existing treatment, the limited or skewed communication abilities of actively suicidal children, and engaging in difficult discussions that may cause undue hardship or re-traumatization. There is a significant gap in the literature that ignores children's own voices due to the confidentiality measures that protect this sensitive population. Parents, who may be very knowledgeable about their child's suicidality, may have experienced secondary trauma and may not have the professional or clinical understanding nor objectivity needed to describe their child's experiences and course of treatment for the creation of a theory. As such, treatment provider perspectives of those who have worked directly with suicidal children are needed to identify the needs of this population and to build a grounded theory to describe children's suicidality. This study utilized current treatment providers who are experienced in the topic of children's suicidality, as well as data derived from treatment charts of suicidal children, to expand knowledge in this area.

## Brief Summary of Relevant Literature

Contemplating the end of one's life is part of the human experience, and counselors should be prepared to work collaboratively with clients in having end-of-life discussions. In fact, this skill can be considered a counseling competency, and is also an ethical guideline specified by the American Counseling Association (ACA, 2005, A.9.). However, the act of death by suicide (the currently preferred terminology, instead of *committing suicide*), remains a very controversial and culture-laden subject. At times, it seems that broaching the subject at all is taboo and carries great stigma (O'Connell, 2012; Rogers & Soyka, 2004). In addition, there are many ongoing myths about suicide – such as, “You can tell who will die by suicide by their appearance” (Joiner, 2010), “...children kill themselves impulsively on the spur of the moment,” (Orbach, 1988), or the most dangerous myth, “Children do not commit suicide...and are incapable of planning suicide” (Davis, 2004, p. 214). The controversy, paired with realistic concerns about the feasibility of clinical research on young suicidal clients (Cwik & Walkup, 2008), has made literature on the subject quite sparse until approximately the past decade.

Fortunately, there does seem to be an increase in literature published on the topic of children's suicidality since 2000 with respect to risk factors, children's understanding of suicidality, and considerations for intervention. There are many risk factors for children's suicidality, including:

- depression (Ben-Yehuda et al., 2012);
- a family history of completed suicide (Dervic, Friedrich, Oquendo, Voracek, Friedrich, & Sonneck et al., 2006; O'Connell, 2012; Rajalin, Hirvikoski, & Jokinen, 2012);

- trauma, including abuse and neglect (Lopez-Castroman et al., 2012);
- family discord (Asarnow, Carlson, & Guthrie, 1987; Cheng et al., 2009; Dervic et al., 2006; Fernquist, 2000; Hawton & Harriss, 2008; O'Connell, 2012; Pomerantz, Gittelman, Farris, & Frey, 2009);
- school stressors (Hawton & Harriss, 2008; Pomerantz et al, 2009);
- low self-esteem (McGlothlin, 2008; Whetstone, Morrissey, & Cummings, 2007);
- low socioeconomic status (Fite, Stoppelbein, Greening, & Preddy, 2011; Holtmann, Buchmann, Esser, Schmidt, Banaschewski, & Laucht, 2011); and
- access to lethal means (Ben-Yehuda et al., 2012; Davis, 2004).

With research ethics strictly protecting children and vulnerable populations, the access to information about children's suicidality may be limited, which may account for the underrepresentation in specific literature.

Literature indicates that children have the capacity to understand the concept of suicide, and the permanence of death (Siegal, 2008; Mishara, 1999). In fact, researchers feel that children have a good concept of suicide before age 10 (Dervic et al., 2006; Skala et al., 2012). However, Pfeffer (1986) suggested that a better definition for children's suicidal behavior is: "any self-destructive behavior that has an intent to seriously damage oneself or cause death." This definition allows for the child to have a concept of death that is meaningful on an individual level.

A challenge in diagnosing or assessing young children with suicidality is that this age group may present with symptomatology and warning signs that are different than that of adults (Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008). They may also use different means of self-injuring or attempting suicide (Mazza, 2006). To illustrate the

difference between child and adult suicidality, consider the warning signs of suicide published by the American Association of Suicidology (n.d.). This association utilizes a mnemonic, “IS PATH WARM,” that stands for: Ideation, Substance abuse, Purposelessness, Anxiety, Trapped, Hopelessness, Withdrawal, Anger, Recklessness, Mood changes. For children under age 10, emotions such as “purposelessness” may necessitate more cognitive complexity than is appropriate considering their developmental stage. In addition, substance abuse is not commonly a childhood concern. Instead of assuming that a child is not at risk for suicide because they do not meet the criteria above, it is essential for mental health professionals to determine and assess for age-specific warning signs for children under age 10.

A combination of risk factors poses increasing risk for suicidality for young children (Tishler, Reiss, & Rhodes, 2007). Protective factors may help to balance this risk, and are an individual source of strength for at-risk children. Interventions aimed specifically at suicidal children are rare, and the literature indicates that there is a lack of awareness or preparedness to address suicidality among families (Flannery, 2006), schools (*Girard v. Town of Putnam*, 2008), and hospitals (Horowitz, Wang, Koocher, Burr, Smith, Klavon, & Cleary, 2001). Nonetheless, school district-wide proactive interventions that cover grades kindergarten through 12 have been effective in decreasing the number of youth suicides (Zenere & Lazarus, 2009).

### **Study Purpose**

Ongoing myths about suicide (Joiner, 2010) that suggest that young children are not affected by suicidality, when clearly they experience the full spectrum of ideation, behaviors, attempts, and completions (WHO, 2010). In addition, the literature on

suicidality is often misleading by using the terminology “children and adolescents,” without indicating a specific age range, or referring globally to children, adolescents, and young adults. As a result, the literature is challenging to interpret and therefore quite vague about the specific characteristics of children’s suicidality, the factors that influence children’s suicidality, and treatment implications for suicidal children aged 10 and younger. There is a strong and documented need for empirical studies that investigate this phenomenon as a distinct construct (Davis, 2004).

This study was designed to develop a theory on childhood suicidality for children 10 and younger that is unique and separate from adolescent and adult suicidality. The qualitative methodology of grounded theory was chosen to systematically collect and analyze data derived from interviews about treatment providers’ experiences with suicidal children, and from suicidal children’s closed treatment charts. The treatment charts will be used to triangulate data from the treatment providers’ reports with actual client data. The treatment charts will also serve as extant texts, which Charmaz (2012) described as valued due to “relative availability, typically unobtrusive method of data collection, and seeming objectivity” (p. 37).

### **Research Questions**

The research questions are as follows:

1. ) What are the characteristics of suicidality in children 10 years and younger?
- 2.) What factors influence childhood suicidality?
- 3.) What are the treatment implications for children 10 years of age and younger who present with suicidality?

## Definition of Terms

The following definitions identify and explain key terms that will be used throughout this study. Specifically, the researcher aims to

- define categorical differences between Children, Adolescents, and Adults;
- identify the spectrum of Suicidality, which includes:  
     Suicidal Ideations,  
     Suicidal Plans (components include: Intent, Means, Lethality, and Immediacy),  
     Suicidal Behaviors,  
     Suicide Attempts, and  
     Suicide;
- and explain the roles of Treatment Providers, and
- Treatment Charts, in the scope of this research study.

**Children.** Those aged zero to 10. The age at which children can comprehend the construct of suicide is a longstanding debate in professional literature (Davis, 2004; Dervic, et al., 2006; McGlothlin, 2008; Mishara, 1999). Facts on deaths by suicide indicated that suicidality increases with age – especially in the adolescent years (WHO, 2010), but no lower age limit seems to ever be explicitly stated. The WHO's reporting on deaths by suicide starts at age five, but other authors have indicated that suicidal behaviors have been observed in children as young as four (Skala et al., 2012), and that preschool-age children are able to understand the concept of death (Siegal, 2008). In addition, depression, or at least a depressive affect, has even been observed in infancy (Luby, 2009; Shamoo & Patros, 1997).

**Adolescents.** Those aged 11 to 17. This age group has been referred to by many different names, including pre-teens, tweens, and teenagers. This research will focus only on elementary-aged children, and will exclude adolescents.

**Adults.** Those aged 18 and older.

**Suicidality.** A measure of suicidal thoughts, feelings, or actions that fall on a spectrum of lethality – from absent lethality, for normal thoughts about death and dying without the intent to die; to high lethality, for intending to engage in behaviors that result in death (Pfeffer, 1986).

**Suicidal Ideation.** Thoughts of ending one's own life, which can be within normal limits of the human experience (i.e., many people consider the construct of suicide and what it means to them) or can fall within the realm of psychological distress and psychopathology. Specifically for adolescent girls, suicidal ideation has been shown to have predictive validity for future suicide attempts (King, Jiang, Czyz, & Kerr, 2013), however, verbalizations of ideation should be responded to by clinical assessment for all genders (Davis, 2004).

**Suicide Plan.** A set of actions that an individual considers to cause their own death. This plan may be feasible or not, but should always be considered a serious indicator of distress. Suicide plans can be evaluated by several criteria: intent, means, lethality, and immediacy.

**Intent.** The extent to which the individual wants to end their life, and the desire to carry out a suicidal plan. For example, a child feels terrible about their life and has even thought about what death might be like, but they have no desire to actually end their life

(no or low intent). Or, a child feels hopeless and helpless and plans to jump off the roof of their apartment building over the weekend (high intent).

**Means.** The accessibility that an individual has to lethal objects or methods of death. For example, a child might report that he plans to walk out onto a busy street to get hit by a car. This plan seems well within the child's control, and there are busy streets nearby to the child's home and school (means). Or, consider a child who reports that he is going to shoot himself in the head with a pistol, but has no access to a gun (no means). While this plan is less feasible, it should still be taken seriously. The greater means that the child has to carry out the suicidal plan, the more dangerous the threat of suicide becomes.

**Lethality.** Lethality refers to the capability for the suicidal plan to cause one's death. For example, a child might state, "I'm going to hit myself in the head with my baseball bat over and over." While this plan might cause bodily damage, it might not immediately cause death (low lethality). An example of a more lethal plan might be, "I'm going to take all 30 of my grandma's blood pressure pills." This plan is quite dangerous, and also very specific (high lethality). The more details in the plan, the more evidence that a child has seriously considered taking action.

**Immediacy.** Immediacy refers to how soon the child might be prepared to enact a suicidal plan. For instance, if a child said, "I am going to take the pills on Sunday when my grandmother goes to church," this gives a very specific window of when the plan might take action (high immediacy). However, if the child said, "I have been thinking of hurting myself in the next month or two," the plan is less immediate, and the child may be more open to interventions to interrupt the plan (low immediacy).

**Suicidal Behaviors.** Actions taken by an individual that places them in physical danger, with or without the specific intent to die. This definition conflicts with literature that suggests that suicidal behaviors are always intended to cause death. However, in defining a child's suicidal behaviors, consider the example of head banging. While self-injurious and possibly lethal if done to an extreme, head banging is an example of a suicidal behavior that may represent the outward expression of psychological pain, but may not be indicative of a child's desire to die.

**Suicide Attempts.** Actions taken to intentionally end one's life, but do not successfully result in death. Suicide attempts are generally of high lethality, but are interrupted by natural means or outside intervention. For example, a child might intentionally cut their wrists to end their life, but the inflicted cuts do not cause enough blood loss to cause death (attempt interrupted by natural means). Or, a child might try to hang himself with a bed sheet, but is discovered by an adult and removed from the situation (attempt interrupted by outside intervention). As explained by O'Carroll, Berman, Maris, Moscicki, Tanney, and Silverman (1996), suicide attempts do not necessarily result in injury.

**Suicide.** A death caused by a person's own actions (self-inflicting an injury/illness or putting oneself in harm's way) to intentionally end one's life. This is also known as a suicide completion and infers that the individual has moved through all phases of the suicidality spectrum.

**Treatment Provider.** Any individual who has directly provided therapeutic services to a suicidal consumer. This may include but is not limited to: counselors, social workers, direct care providers, clinical supervisors, psychiatrists, advanced practice

nurses (APN's), medical doctors involved in mental health treatment, and related personnel.

**Treatment Chart.** A treatment chart, also known as a *client chart* or *client record*, is a document that contains clinically relevant information about one specific client. The treatment chart not only tracks a child's progress in counseling, but also includes documents from other domains of the child's life, such as: demographic information, a summary of psychosocial history (including a family history), physical health tracking, psychiatry and medication logs, educational progress reports, insurance information, and collaborative contacts.

## CHAPTER TWO

### LITERATURE REVIEW

#### **Introduction**

Suicide and suicidality have been researched extensively in adolescent and adult populations, but it has not been until recent years (2000 and beyond) when children's suicidality, especially in pre-pubescent children, has specifically been explored as a distinct subject. From this emerging research, several areas have been identified as critical constructs to children's suicidality. This chapter will explore the current research on the spectrum of children's suicidality, including the following areas: prevalence, young children's comprehension of death and suicide, risk and protective factors, symptomatology, common methods of children's suicidal behaviors, assessment strategies, treatment modalities, and specific interventions. The literature reviewed may indicate how suicidal children's holistic presentation and needs are distinctly different from their adolescent and adult counterparts. This review will also identify current gaps in children's suicidality literature and methodology in order to inform future research.

A recent search on PsycINFO for the term *suicide* in the past five years resulted in approximately 16,397 hits for articles, dissertations, and books on the subject. Of those, 12,772 (about 78%) were written on adult age groups; 2,030 (about 12%) on adolescents; and only 1,595 (about 10%) on children. Although these figures seem to reasonably represent the world population of children and adolescents, an actual review of the literature shows that children are not well represented in articles at all – even for those with “child” or “children” in the title. Without reading each specific article, it is impossible to tell the authors' definitions of “children,” because there is no commonly

agreed upon age range to define the group. For example, Hepp, Stulz, Unger-Köppel, and Ajdacic-Gross (2012) wrote an article called, “Methods of suicide used by children and adolescents.” This title would lead one to assume that children are represented in the sample, but out of 333 examined suicides in Switzerland from 1998-2007, zero suicides in the 0-19 age group were made by children younger than 12 years old. Similarly, Hawton, Bergen, Kapur, Cooper, Steeg, Ness, and Waters (2012), was published entitled, “Repetition of self-harm and suicide following self-harm in children and adolescents...” The authors examined 5,205 participants labeled children and adolescents, but only four children (about 0.0008%) were under the age of 10, and the youngest was age 7. Finally, Skinner and McFaull (2012) wrote an article called, “Suicide among children and adolescents in Canada...” in which they defined “children” as aged 10-14 and “adolescents” from age 15-19. It seems that an age group 10 years and younger has not been adequately studied in the literature on suicidality. Clearly, the term *children* is not a standardized construct in literature on children’s suicidality. In fact, as demonstrated through the above-mentioned examples, the true research on children’s suicidality (when “children” refers to ages 10 and younger) is actually sparse and difficult to identify.

Interestingly, some of the ostensibly pertinent and complete literature on children’s suicidality comes from textbooks (e.g., Capuzzi, 2004; McGlothlin, 2008) as opposed to peer-reviewed journal articles. It may be that clinicians who have had regular access to children who have experienced childhood suicidality are able to publish more conceptual pieces on the subject than researchers, who may have difficulty studying suicidal children due to prohibitive research ethics designed to avoid liability issues. In any event, it is important to recognize the language differences and terminology in texts

as well. For example, Ash (2012) wrote a chapter called, “Children, Adolescents, and College Students,” in the *Textbook of Suicide Assessment and Management* (Simon & Hales). This work largely ignored children, while it provided many case study examples of teenagers and young adults.

### **Prevalence of Childhood Suicidality**

Child suicide rates in the United States are alarmingly high. Although the WHO (2010) cites that rates are only 1.0 per 100,000 for male and 0.3 per 100,000 for females ages 5-14 years, this actually translated to the deaths of 204 males and 64 females ( $N = 272$ ) by suicide in the year 2005 alone. In addition, a completed suicide for children and adolescents ages 5 to 9 happens approximately once every two days in the United States alone (WHO, 2010). This may appear a low number of cases overall, however, Cheng et al. (2009) noticed that, according to hospital records, the rate of failed suicide attempts in adolescents are 50-100 times than those completed. When one calculates this range using the 2005 statistic that 272 youth completed suicide, this suggests that 13,600 to 27,200 youth ages 5-14 years attempted suicide. One can conclude that exponentially more children experienced suicidal ideation, but did not engage in self-harm behaviors. Some have suggested that suicidal ideation amongst children is as high as 20% (Fite, Stoppelbein, Greening, & Preddy, 2011), and Pfeffer (1986) described suicidal ideation, threats, and attempts for children under 12 as “relatively common” for all socioeconomic backgrounds (p. 37).

Of course, statistical figures on suicide rates only represent confirmed cases of suicide. However, it is widely accepted that due to reporting error, stigma surrounding suicide, and familial denial, actual figures might be significantly greater (Davis, 2004;

Shamoo & Patros, 1997). Others report rising suicide rates for young people across the globe (Arslan, 2007; Bertolote & De Leo, 2012; Fernquist, 2000; Miller, 2009; Windfuhr, 2008). These rates range from very low: 0.0 per 100,000 in countries such as Haiti, Grenada, and Antigua and Barbuda; moderate: 1.3 in Korea (1.2 for males, 1.3 for females), 1.5 in Lithuania (1.7 for males, 1.2 for females); to very high: 3.7 in Kazakhstan (5.6 for males, 1.7 for females), 5.6 in Guyana (6.2 for males, 5.1 for females) (WHO, 2013), and Greenland, where it has been reported that up to 1 in 4 to 5 teenagers attempts suicide (Moshiri, 2010). It is logical to conclude, then, that suicidality is a worldwide public health crisis, which has serious implications for youth.

The subject of suicidality amongst young people has gained much attention in the past several years, as research shows that very young people can and do end their own lives (Fernquist, 2000). By the time children reach high school, approximately 37.9% of them have experienced suicidal ideation (Skala, Kapusta, Sclaff, Unseld, Erfurth, Lesch...Akiskal, 2012). Unfortunately, in research, children 10 years old and younger are generally lumped into adolescent and young adult age brackets during statistical analyses of suicidal behaviors – for example, from ages 0-21 – despite the fact that children 10 and under have unique emotional needs, with different diagnostic features, including symptoms of depression, triggers for suicidality, and methods of self-harm (Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008). The low rates of completed suicides in children 10 and under lead to the misconception that young children are not capable of such feelings or behaviors. However, Shamoo and Patros (1997) reported that suicidal behaviors stem from underlying depression that can start as early as infancy. Additionally, researchers now call for interventions to begin as early as preschool and

kindergarten (Barrios, Sleet, & Mercy, 2003; Fite, Stoppelbein, Greening, & Preddy, 2011; Zenere & Lazarus, 2009).

Unfortunately, despite the rates of children's suicidality and multiple risk factors that are known to the public, many helping professionals continue to believe that children do not understand death and its permanency, and cannot engage in intentional acts to end their lives (Davis, 2004). This myth may be contributing to a lack of intervention. To dispel this myth, Siegal (2008) performed a study that showed how children are capable of understanding the meaning of death by 4 years of age, and can distinguish between "alive" and "dead," as well as "dead" and "sleeping."

Mishara (1999) interviewed elementary school children in Grades 1-5 and found that 71% of children understood the finality of death and all could identify at least one method of committing suicide. Although younger children might not have a full understanding that death is irreversible, and may not be actively considering consequences while engaging in risky behaviors, they are still capable of suicide and related behaviors. Further, by age 10 children do have a comprehensive knowledge of suicide and death (Dervic, Friedrich, Oquendo, Voracek, Friedrich, & Sonneck, 2006).

### **Risk Factors for Childhood Suicidality**

The following risk factors have been shown in the literature to be correlated with children's suicidality. However, one can expect that this list is not exhaustive, as phenomenological experiences can influence an individual's risk for suicidality.

**Biological Risk Factors.** After an extensive review of the literature, distinct studies regarding the biological and neurobiological markers for suicidality exclusively in children do not seem to exist. One study found clinically significant brain volume

differences in the frontal cortex and temporal lobe of suicidal children with epilepsy (Caplan, Siddarth, Levitt, Gurbani, Shields, & Sankar, 2010), which indicated risks of suicidality for epileptic children, but was not generalizable to a non-epileptic population. Alternatively, there is a significant amount of literature emerging focused on biology and suicidality in adult populations, especially in medical (as opposed to *social science*) journals. Some of that research is summarized in this section.

Some individuals may be biologically predisposed to depression, which can lead to suicidal ideation with the addition of external stressors or risk factors, and low or absent protective factors. Although research on the relationship between genetics and suicidality has been long underway, “Knowledge on the exact neurobiological and genetic systems responsible for suicidal vulnerability is far from clear” (Antypa, Serretti, & Rujescu, 2013, p. 1126). After examining biological studies on suicidology that included twin studies, Bondy, Buettner, and Zill (2006) estimated that “43% of the variability in suicidal behaviour may be explained by genetics, while the remaining 57% may be explained by environmental factors” (p. 337). The biological marker that currently seems to be related to suicidality is a lower level of the neurotransmitter serotonin (Flannery, 2006) and its related serotonergic genes (Antypa, Serretti, & Rujescu, 2013). Again, however, this research refers largely to adult populations.

Previously, biological research in the field of suicidology only explored pre-existing genetic markers, as if researchers were looking for a naturally-occurring “suicide gene” that could be identified and perhaps altered to prevent suicidality. As mentioned above, scientists have narrowed their study to the serotonergic system as a possible indicator of suicide, which still remains critical to today’s research. Interestingly, though,

a recent development in suicide research has focused on the *epigenetics* of suicide, which is defined as how the environment affects the genome, or the biology, chemistry, and physics of the human body on a molecular level (Labonte & Turecki, 2010). Now, researchers are exploring how the effects of childhood adversity (including many of the childhood risk factors for suicidality explained in this literature review, e.g., childhood physical and sexual abuse) physically changes one's biology, and how these genetic modifications may influence later suicidality (Labonte & Turecki, 2010; Perroud, Courtet, Vincze, Jaussent, Jollant, Bellivier, ...Malafosse, 2008). In fact, more severe childhood adversity seems to affect more dysfunction in the body and may promote more aggressive and violent suicidal behavior (Perroud et al., 2008).

A final biological factor that is correlated to suicidality is a family history of attempted or completed suicide (Dervic et al, 2006; O'Connell, 2012; Rajalin, Hirvikoski, & Jokinen, 2012), especially amongst primary relatives (Qin, Agerbo, & Mortensen, 2002). This risk factor may have both biological and social implications, as there can be both a genetic link and also learned behaviors from the family member. To clarify, Brent and Mann (2005) insisted, "Familial clustering of suicidal behavior cannot be explained by imitation alone," after their extensive review of research on adoption studies showed higher suicide rates among adoptees who had no contact with suicidal biological relatives (p. 22). In addition, it has been shown that children who have a biological family history of suicide make their own suicide attempts at earlier ages, on a more frequent basis, and by more severe means (Lopez-Castroman et al., 2012).

**Familial Risk Factors.** Family discord is perhaps the most common reason cited in the literature that leads children to suicidal thoughts (Asarnow, Carlson, & Guthrie,

1987; Cheng et al., 2009; Dervic et al., 2006; Fernquist, 2000; Hawton & Harriss, 2008; O'Connell, 2012; Pomerantz, Gittelman, Farris, & Frey, 2009). For instance, one group that is particularly affected by family discord is Asian Americans, who have a “30-fold increase in risk for suicidal behaviors when they experience high levels of intergenerational conflict” (Lau, Jernewall, Zane, & Myers, 2002).

**Diagnostic Risk Factors.** Mental illness is another issue highly correlated to suicidality. For very young children who experience suicidality, mental health diagnoses may not have been made prior to suicide attempts or completions. Posthumous interviews with family members, or “psychological autopsies,” may shed light on certain mental conditions that may have been present but undiagnosed. At the same time, there are some known diagnoses, in particular, that seem to be correlated to suicidal behaviors. According to psychological autopsies, in which researchers posthumously explored children’s psychosocial histories, depression is the diagnosis that presents the highest risk, and has been shown to be present in up to 60% of children who have died by suicide (Ben-Yehuda, Aviram, Govezenski, Nitzan, Levkovitz, & Bloch, 2012). A longitudinal study of 1,420 children – including a cohort of 9 year olds, entitled *The Great Smoky Mountains Study*, found that specific diagnoses comorbid with depression, such as anxiety and disruptive disorders, also increase the risk of suicidality (Foley, Goldston, Costello, & Angold, 2006).

Other diagnoses highly related to suicidality are as follows: anxiety disorders (O’Neil, Puleo, Benjamin, Podell, & Kendall, 2012), substance abuse (O’Connell, 2012), conduct disorder, schizophrenia, and borderline or antisocial personality disorders (Mazza, 2006). One should note that some of these diagnoses would not be appropriate

for children under the age of 10 – for example, schizophrenia and personality disorders are not likely to be diagnosed until early adulthood. To separate diagnostic differences between children and adolescents, Ben-Yehuda et al. (2012) conducted a study in Israel on suicidality in children and adolescents and found that children under age 12 (nearly 15% of a sample of 266), who presented to an emergency department with suicidal ideation or attempts were most commonly diagnosed with adjustment disorders (38.5%), attention deficit hyperactivity disorder (ADHD; 25.6%), and/or conduct disorders (23.1%). This was different from the adolescent patients, who were more commonly diagnosed with adjustment disorders, unipolar depression, and conduct disorders. The authors suggested that the impulsivity related to ADHD created increased risk. This was echoed by Hinshaw, Owens, Zalecki, Huggins, Montenegro-Nevado, Schrodek, and Swanson (2012), who found that girls, in particular, diagnosed with ADHD Combined Type were at increased risk for suicidality. These findings show that suicidality in children is different than suicidality in adolescents.

Another diagnostic risk factor for childhood suicidality is autism (Mayes, Gormann, Hillwig-Garcia, & Syed, 2013). Children with this diagnosis have been found to be at 28 times a greater risk for suicide. While this diagnostic group may have less risk for suicidality than those diagnosed with depression, they continue to be at significant risk. The National Institute of Mental Health (NIMH) reports that 1 in every 110 children in the United States are diagnosed with Autism Spectrum Disorders (NIMH, n.d.), which indicates a large population of children who are at elevated risk for suicidality.

Studies from Europe have indicated that self-harming behaviors, such as cutting, regardless of the intent, are considered a risk factor for suicidality (Hawton, Bergen, Kapur, Cooper, Steeg, Ness, & Waters, 2012). Although the American Psychiatric Association [APA] considered “Non-Suicidal Self-Injury” its own distinct diagnosis for inclusion in the Diagnostic and Statistical Manual for Mental Disorders, 5<sup>th</sup> Edition (*DSM-5*, APA, 2013), researchers from other countries pushed for self-injurious behaviors to remain distinctly related to suicidality. Children who self-injure, or who seem to not be alarmed by physical injury (e.g., scraping their knee, T. Joiner, personal communication, April 6, 2013), may have varying intents, but they should also be considered a focus for clinical attention, as related to suicidality.

**Developmental Risk Factors.** Any significant trauma that occurs at a young age can affect a child’s development and risk for suicidality (Lopez-Castroman et al., 2012). Children who do not have cognitive (or non-aggressive) coping skills may view suicide as their only option to end suffering from specific traumas (Asarnow, Carlson, & Guthrie, 1987). The traumas specifically mentioned in the literature that have been especially linked to suicidality include the following:

- Physical abuse (Andover, Zlotnick, & Miller, 2007; Dervic et al, 2006; O’Connell, 2012; Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008);
- Sexual abuse (Andover, Zlotnick, & Miller, 2007; Dervic et al, 2006; Hawton & Harriss, 2008; O’Connell, 2012; Pomerantz, Gittelman, Farris, & Frey, 2009; Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008);
- Witnessing domestic violence (Rajalin, Hirvikoski, & Jokinen, 2012; Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008);

- Being removed from their home due to maltreatment (Johnson-Reid, Kohl, & Drake, 2012; O'Connell, 2012; Rhodes et al., 2012) or because they were orphaned (Zapata et al., 2013). Children removed from their homes have been shown to be five times more likely to experience suicidal ideation (Rhodes et al., 2012);
- Incarceration or involvement with the juvenile justice system (O'Connell, 2012; Wasserman & McReynolds, 2006); and
- Hunger (McIntyre, Williams, Lavorato, & Patten, 2012).

It is important to recognize that these traumas are not necessarily a cause of suicidality in children, as many children learn coping mechanisms and are generally resilient when faced with adversity (Davis, 2004). However, trauma may feel insurmountable to young children, and those traumas which are ongoing will have a more lasting effect, thus increasing risk for suicidality more than those which occur once, or that are temporary. In addition, as mentioned previously, researchers now feel that early childhood traumas may cause measurable physical changes in the body that may have lifelong effects to suicidality (Labonte & Turecki, 2010; Perroud et al., 2008).

Table 1.

*Risk by Traumatic Event or Experience*

<b>Risk Factor</b>	<b>Age Group</b>	<b>Author(s) &amp; Date</b>
Childhood Physical abuse	Childhood	Andover, Zlotnick, & Miller (2007)
	5-14 years	Dervic et al. (2006)
	Children & Adolescents	O'Connell (2012)
	9-12 years	Riesch, Jacobson, Sawdey, Anderson, & Henriques (2008)

	Childhood	Zapata et al (2012)
Childhood Sexual abuse	Childhood	Andover, Zlotnick, & Miller (2007)
	5-14 years	Dervic et al. (2006)
	Under 15 (range 8-14)	Hawton & Harriss (2008)
	Children & adolescents	O'Connell (2012)
	10-14 years	Pomerantz, Gittelman, Farris, & Frey (2009)
	9-12 years	Riesch, Jacobson, Sawdey, Anderson, & Henriques (2008)
	Childhood	Zapata et al (2012)
Witnessing domestic or interpersonal violence as a child	Childhood	Rajalin, Hirvikoski, & Jokinen (2012)
	9-12 years	Riesch, Jacobson, Sawdey, Anderson, & Henriques (2008)
<b>Being removed from their home</b> (due to maltreatment and/or due to being orphaned)	1.5 to 11 years	Johnson-Reid, Kohl, & Drake (2012)
	Children & adolescents	O'Connell (2012)
	12-17 years	Rhodes et al. (2012)
	Childhood	Zapata et al. (2013)
Incarceration or involvement with juvenile justice	Children & adolescents	O'Connell (2012)
	Under 18 years	Wasserman & McReynolds (2006)
Hunger in childhood	0-25 years	McIntyre, Williams, Lavorato, & Patten (2012)

*Note.* "Childhood" age groups represent adult data collection regarding childhood experiences.

**Social Risk Factors.** Support groups outside of the family are also very important to young people. Children spend the majority of their time navigating school stressors – which themselves can be a risk factor for suicidality (Hawton & Harriss, 2008; Pomerantz et al., 2009) – but also the complicated peer relationships in the school setting. Bullying is a “hot button” issue related to suicidality in young people (Flannery, 2006), but so are the lesser-known issues of relational aggression (Fite, Stoppelbein, Greening, & Preddy, 2011), which includes behavior such as spreading rumors about and/or ignoring or excluding a peer, which may lead a child to feel low self-esteem, loneliness, depression, and even suicidal ideation. Therefore, it is not only the overt behaviors of bullying, commonly thought of as pushing, teasing, stealing from, harassing, etc., that can lead to thoughts of ending one’s life, but the more subtle behaviors, as well. Increased risk is present for children who internalize their feelings and those who engage in reactive aggression (as opposed to proactive aggression; Greening, Stoppelbein, Luebke, & Fite, 2010).

**Educational Risk Factors.** School itself can also create risk factors for children to become suicidal. When school is perceived as excessively challenging or demanding (i.e., as with homework), it can create an enormous amount of stress on children. The pressure to perform well has been cited by students as a risk factor of suicidality (Hawton & Harriss, 2008). School failure has been reported to increase feelings of depression and suicidality (Dervic et al., 2006), as well as disciplinary problems (Pomerantz, Gittelman, Farris, & Frey, 2009). As children’s behavior and school performance are often measured against that of their peers, academic underachievement and other school

problems may lead to feelings of isolation, worthlessness, frustration, depression, and more.

**Individual/Emotional Risk Factors.** One individual risk factor for suicidality in children is self-image, and more specifically, their perceived weight status. Whetstone, Morrissey, and Cummings (2007) completed a study on the weight of middle school students in North Carolina, and found that children who perceived themselves to be overweight were more apt to have low self-esteem, often made somatic complaints, and experienced depression – all risk factors correlated with suicidal ideation and behaviors. Low-self esteem, by itself, has also been cited as a risk factor for suicide, as children can feel that they are not worthy to go on living (Fite, Stoppelbein, Greening, & Preddy, 2011). It is important to recognize that many of the individual risk factors for suicidality in children are manageable with appropriate intervention from adults.

An additional internal or individual risk factor for children's suicidality is psychological pain (Miller & Eckert, 2009). If the child's environment and caregivers are unsupportive, a heightened level of stress can lead to feelings of hopelessness, helplessness, worthlessness, loneliness, and depression – all of which are risk factors for suicidality (Fite, Stoppelbein, Greening, & Preddy, 2011; McGlothlin, 2008).

**Environmental/Societal Risk Factors.** Finally, other social issues have been reported to affect children's suicidal thinking. First, the media frequently portrays suicide as a normal escape from painful situations, and children are particularly susceptible to influences from television and movies (Miller & Eckert, 2009; Mishara, 1999). Even cartoons present children with methods for ending one's life, and this glorification of suicide as a valiant way to die can suggest methodology and bring

normalcy to suicide. This risk factor may be controlled either by the responsible media sources (Blood & Pirkis, 2001; Hawton & Williams, 2001), or by caregiver control of media to children.

Second, access to lethal means plays a significant role in a child's ability to take their own life. Grossman et al. (2005) reported that access to guns – especially unlocked guns and their ammunition – provided an increased risk for child suicides. While the correlation between suicidality and access to firearms has been researched extensively in the adolescent and adult populations (for example, Ben-Yehuda et al.'s 2012 study of Israeli teens who are mandated to complete military service and subsequently become gun owners), children's access to weapons is not discussed in suicide literature. Davis (2004) noted how adults are more likely to classify a child's death by firearm as an accident, as it seems less stigmatizing and more acceptable.

Oshima et al. (2012) explored cell phone use by 17,920 Japanese adolescents after their bedtime and "lights out" and found that those who continued to use their cell phones when they should have been sleeping were at increased risk for suicidality. There are many possible explanations for the youths' behavior that may have impacted suicidal ideation, which need further investigation. However, as cell phones and other technologies (e.g., tablets, electronic readers, portable music players, laptops, and any device with access to the Internet) are becoming more popular and accessible for use by children, it seems that the risk for suicidality may increase with increased use of electronic devices after bedtime (Oshima et al., 2012). Technology use certainly affects children under age 10, as The Henry J. Kaiser Family Foundation reported that 31% of all 8-10 year olds own a cell phone, which gives them access to talk, text, and media features

(e.g., playing games, listening to music, and watching TV (Rideout, Foehr, & Roberts, 2010)).

Finally, low socioeconomic status has several compounding effects on children's suicidality (Fite, Stoppelbein, Greening, & Preddy, 2011; Holtmann, Buchmann, Esser, Schmidt, Banaschewski, & Laucht, 2011). Foley, Goldston, Costello, and Angold (2006) studied suicidality in 1420 children ages 9-16 and found that poverty is not a predictor for psychiatric disorders, but it is associated with suicidality. Children of low socioeconomic status may have more stressors than children of higher socioeconomic status due to the limited resources of their family and community. In addition, these children may have less access to mental health care even if a problem is identified or if the family is aware of suicidality.

### **Protective Factors**

Luckily, there are protective factors that seem to naturally prevent young people from death by suicide. One natural protective factor is "the skills and ability to solve problems" (American Foundation for Suicide Prevention, 2013, pp. 3). Additionally, many protective factors are simply the opposite of risk factors (Haley, 2004), and intuitively, interventions can be made to reduce the effects of risk factors across domains. However, not all risk factors can easily be reversed, so it may be more helpful to focus on the addition of protective factors as opposed to the subtraction of risk factors. For example, as family discord is a known risk factor for suicidality amongst children, having a supportive home environment would be ideal but perhaps not possible in the short-term. Instead, adding a separate protective factor may be more effective. As O'Connell (2012)

suggested, generally building resiliency as a protective factor is a place where adults might start to help.

There are numerous protective factors that have been shown to decrease suicidality across age groups. Several of the following protective factors were chosen for their ability and evidence-based history to apply to young children. First, Ben-Yehuda, et al. (2012) in Israel found the strength of a religious community was a protective factor. For teachers and educators, Mata, van Dulmen, Schinka, Swahn, Bossarte, and Flannery (2012) showed that increased school connectedness was associated with decreased isolation, and therefore likely decreased suicidality. Finally, Ramey, Busseri, Khanna, Hamilton, Ottawa, and Rose-Krasnor (2010) showed that extracurricular involvement – which may come from school or community – increased self-esteem, coping skills, and social support networks, which are all independent protective factors. While this study focused on adolescents, there seems to be a possible application for younger children. The best extracurricular activities to decrease the risk of suicidality were shown to be sports or physical activities, volunteer work, organized clubs or interest groups, and educational activities. Interestingly, fine or performing arts activities were not shown to be a protective factor, which may be an area for future research (Ramey, Busseri, Khanna, Hamilton, Ottawa, & Rose-Krasnor, 2010). Finally, The American Foundation for Suicide Prevention (2013) also reported that effective mental health care is a protective factor.

### **Symptomatology**

It is critical that suicidality for children, adolescents, and adults, be viewed on a spectrum, ranging from normal thoughts of death and dying, to urges to self-harm, to

reckless endangerment, and finally to suicide itself (Hawton & Harriss, 2008). As mentioned in Chapter One, adolescents and adults may have a range of symptoms for suicidality that the American Association of Suicidology (n.d.), expressed with the acronym, “IS PATH WARM,” which included a range of emotional expression, such as hopelessness, withdrawal, and recklessness. With very young children, however, it may be difficult to determine what they are thinking and feeling because they may not have the vocabulary to vocalize risk signs of sadness and depression to adults (Pfeffer, 1986). Children might present with mild symptoms, such as headaches or stomachaches, changes in eating or sleeping habits, and behavioral outbursts (Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008). However, more intense presentations are not unusual, and may be observed as self-destructive behaviors (Greening, Stoppelbein, Luebbe, & Fite, 2010), or “severe affective and behavioral dysregulation, including irritability, aggression, ‘affective storms’, hyperarousal and mood instability” (Holtman, Buchmann, Esser, Schmidt, Banaschewski, & Laucht, 2011). Still other children might only demonstrate suicidality through play and enactments of emotions of which they may not be fully aware (Pfeffer, 1986). Research presents a wide range of possibility for the presentation of suicidality (Orbach, 1988). As Orbach described: “Messages concerning death among the young include death wishes and suicide threats; displays of pathological curiosity regarding death; repeated games dealing with death and suicide; and, more obliquely, drawings, songs, and stories of destruction” (1988, p. 35). Therefore, any mention of suicidality or signs of self-harm should be taken quite seriously by adults (Davis, 2004; Flannery, 2006; Hawton & Harriss, 2008; Joiner, 2005). Adults should pay particular attention to behaviors that are atypical for individual children, such as

withdrawing from social or family activities, worsening school performance, acting out behaviors, mood swings, somatic complaints, or even hallucinations and delusions (Charles & Matheson, 1991).

### **Common Methods Used By Children in Attempting Suicide**

In reviewing the available literature on children's suicidality, it is clear that country of origin (and related culture) is the primary influence on the way in which children attempt suicide (Arslan, Akcan, Hilal, Batuk, & Cekin, 2007). Essentially, children can – and do – die by suicide by all of the same means and methods used by adults. However, some methods are more common in certain countries or cultures than in others. For example, in the United States, the most common methods for youth ages 10 to 24 (there are almost no data for the method of children under 10) are as follows: firearms (45%), suffocation (40%), and poisoning (8%) (CDC, 2012).

Meanwhile, in Turkey, pesticide poisoning is among one of the more common methods, as well as death by hanging and shotgun (Arslan, Akcan, Hilal, Batuk, & Cekin, 2007). In the United Kingdom, self-poisoning (Windfuhr et al., 2008), especially by acetaminophen overdose (Hawton, Bergen, Kapur, Cooper, Steeg, Ness, & Waters, 2012) is common, as well as self-cutting. In Austria, hanging is the most prevalent method of youth suicide (Dervic, Friedrich, Oquendo, Voracek, Friedrich, & Sonneck, 2006). These differences by country tend to be an indirect result of the caregivers' primary occupations, as a function of access to lethal means (such as farming, where pesticides are readily available).

Pomerantz, Gittelman, Farris, and Frey (2009) cautioned that suicide by drug ingestions of psychiatric medications are increasing worldwide, as prescription drugs are

also more widely available. They stated that selective serotonin reuptake inhibitors (SSRIs), typically antidepressant and anti-anxiety medications, are being used more frequently in youth suicidal behavior. Furthermore, the most common hours to act on suicidal ideation seem to be between 4:00 p.m. and midnight, and the most frequent day of the week is Monday (20.7%).

Despite increased research on these more lethal means of suicide, Mazza (2006) claimed that children (as described by the CDC as 5-19 year olds) typically choose methods of suicide that are of low lethality and have a high chance of rescue. This research seems to indicate that young children do not want to die, or are acting out for attention, which may be true, but then ignores children who might be at great risk for suicide completion. Mazza acknowledged that very young children, often omitted from data on method of suicide, do not always have access to lethal means. Therefore, they may resort to more instinctual or creative means to act on suicidal impulse. For instance, very young children might hold their breath, bang their heads repeatedly, run out into traffic, or engage in similar behaviors over which they might have a greater deal of control.

### **Assessment Strategies**

The proper assessment for children's suicidality symptomatology is the first step to effective treatment. Unfortunately, there are limited tools available for mental health workers to assess children who may be experiencing suicidality. Davis (2004) went as far as to say, "inventories used to assess childhood suicide are seemingly nonexistent. This seems to parallel the general attitude toward childhood suicide." (p. 218). In one article, Larzelere, Andersen, Ringle, and Jorgensen (2004), referenced several tests that

specifically addressed presentations of suicidality in children, but admitted that these assessments had many flaws. For example, the assessments were outdated (currently ranging from 16 to 32 years since original publication), did not assess for the entire suicidality spectrum (e.g., ideation only), were largely based on adult symptomatology, were excessively long for children's acute screening needs (2 hours), and had low test-retest reliability in accurately predicting children's suicidality (Larzelere, Andersen, Ringle, & Jorgensen, 2004). These authors went on to develop their own assessment, The Child Suicide Risk Assessment (CSRA), which had significant limitations and is not used in clinical today, as evidenced by a lack of additional articles.

There are several clear issues with children's suicidality assessments. Historically, most assessments have copied or adapted from adult symptomatology, that does not necessarily correlate to children's symptomatology. Second, children often have difficulty understanding the nature and instructions of psychological testing, which presents a barrier to self-reporting measures. A third conflict in assessing children's suicidality is its high correlation with children's mental health symptomatology for several different diagnoses. For example, Holtmann et al. (2000) used a dysregulation profile of the Child Behavior Checklist (a series of empirically validated parent checklists to screen for mental illness by Achenbach, 1991), to assess for suicidality amongst other mental health disorders. After a 19-year longitudinal assessment, the researchers found that increased dysregulation scores on the Child Behavior Checklist were correlated with anxiety and depressive disorders, ADHD, conduct disorders such as Oppositional Defiance Disorder (ODD), and substance abuse problems, in addition to suicidal ideation and attempts (Holtmann et al., 2000). Therefore, it is difficult to isolate children's

suicidality through the use of standardized assessments, especially when comorbid diagnoses can also be present.

Another issue with diagnosis is the tendency for parents to be unaware of, or in denial of their children's suicidal behaviors. Children may hide their behaviors from their parents, or the parents may feel guilty or shameful regarding their children's suicidality (Mojtabai & Olfson, 2008). If parents are unable to seek treatment for the children, the suicidal behaviors may go unnoticed, which may lead to a completed suicide.

A final issue in assessing suicide intent comes when coroners inaccurately report the cause of death of children's suicides (Mishara, 1999; Tishler, Reiss, & Rhodes, 2007). Frequently, when a child dies by suicide, the coroner may report that it was an accidental death. For example, the CDC reported 57 confirmed deaths by suicide for children ages 0 to 9 from the years 1999-2010. During the same time period, 1,977 children died by injuries of "undetermined intent" (CDC, 2013). A misrepresentation of the death event may lead to underreporting of suicides by young people.

The literature to date has provided minimal guidance for treatment providers working with suicidal children. As an alternative to formal assessments, Davis (2004) suggested using informal assessments, such as age- and developmentally-appropriate questioning, and Pfeffer (1986) suggested the observation of play for clues such as themes of violence or death. However, in the absence of specific guidelines and empirical literature to validate such methods, treatment providers may not know how to properly assess for suicidality. Additional research is necessary to determine best practices for identifying and assessing children's suicidality. The effective assessment of

children's suicidality may lead to more timely interventions, which may also prevent suicidal behaviors and suicide-related deaths.

### **Treatment/Interventions**

After a child has been identified as at-risk for suicidality, treatment and intervention are essential components of preventing violence. As one might expect, there are many complications related to this enormous task. First, is determining who is responsible for addressing suicidality in children. As Flannery (2006) explained, some families feel that it is their sole responsibility to know what is happening with their children and to address suicidal thoughts and behaviors in the home. However, as mentioned earlier, familial stress is often a cause of suicidality, and parents do not always recognize their children's distress and symptomatology. Others say that schools should implement interventions (Barrios, Sleet, & Mercy, 2003; Fite, Stoppelbein, Greening & Preddy, 2011; Singer & Slovak, 2011; Zenere & Lazarus, 2009). Schools are often the first place in which a child's suicidality is identified, but not all schools are equipped with the proper staffing and protocol to be able to handle a suicidal student. Many schools do not adhere to the national statute for schools to have a documented and practiced suicide prevention policy, as evidenced by the legal case of *Giard V. Town of Putnam* (2008). In this situation, eighteen year-old Michel Giard committed suicide after having indicated at school that he was planning to kill himself, and a school counselor failed to intervene. It is unclear just how many school districts are in violation of mandates that require suicide prevention and intervention strategies. If schools are to manage children's suicidal behaviors on-site, there must be strictly mandated, enforced, and reported guidelines for intervention.

Optimistically, however, some school suicide prevention and intervention programs are proving effective in recent years. Zenere and Lazarus (2009) reported on the Miami-Dade County Public Schools of Florida, who implemented such a program for their entire population of 350,000+ students in 392 schools, including curriculum, student and faculty trainings, peer intervention programs, and a system of interventions to decrease incidents on the spectrum of youth suicidal behavior. Students aged 5-19 were included, as the program was implemented from elementary through high school levels. The completed suicide rate and the suicide attempt rate declined with clinical significance from the period of 1989 to 2006.

Still other researchers indicate that youth suicidality is a problem to be addressed by the community, including mental health workers, physicians, and the court systems. With regard to community mental health, research shows limited hope for individual talk therapy. As Mazza (2006) pointed out, no one existing therapeutic approach is able to reduce youth suicidal behavior. To the same effect, Huey, Henggeler, Rowland, Halliday-Boykins, Cunningham, and Pickrel (2005) found that multisystemic therapy, an approach usually celebrated for its effectiveness, was no better than psychiatric hospitalization. In addition, incarceration has been found to increase suicidality among young people (Wassermann & McReynolds, 2006). Therefore, it seems that hospitalization is still an option for suicidal youth – and this seems to be the only community resource that will regularly accept children who experience mental health emergencies.

Scholarship in nursing and health care disciplines report the rising number of children reporting to emergency rooms with mental health crises, including suicidal

ideation and behaviors (Horowitz, et al., 2001; Pompili, Mancinelli, Giardi, Ruberto, & Tatarelli, 2004). Recently, physical health care providers seem to have published more data on childhood suicidality than have mental health care providers. This may be due to the sheer volume of clients that hospital emergency rooms are getting, driving a need for further understanding amongst nurses and hospital staff. (It also speaks to the physical health providers' access to data on youth suicides, as mentioned previously.) A limitation to this type of treatment is that, although hospitalization is recommended for children who are at imminent risk for self-harm, obstacles include untrained hospital staff, strict insurance regulations, and a limited number of beds for children's psychiatric needs (Flannery, 2006). Horowitz, Wang, Koocher, Burr, Smith, Klavon and Cleary (2001), reported this unpreparedness with the statistic that, "only 24% of the pediatric hospitals in the United States have mental health specialty services available in the [Emergency Department]" (p. 1134). As suicidality can occur in any location, it seems that treatment availability in hospitals should be universal. However, Horowitz et al.'s findings suggested that 76% of hospital emergency rooms have to turn suicidal children away due to a lack of services.

Previous research has demonstrated a need for the individualized treatment of suicidal children for decades (Tishler, 1980), yet no recent articles have explained what specific treatment interventions should be used or which could be considered best practice. Tamas et al. (2007) suggested that treatment include a focus on increasing children's range of adaptive emotional regulation strategies so that suicide is not the only option that children feel they have to manage their stressors. However, it has still not clearly been identified as to how or by whom this type of treatment should be

implemented. McDougall, Armstrong, and Trainor (2010), explained treatment strategies best: “Preventing self-harm and suicide requires a comprehensive, integrated effort involving children and young people, families and communities, schools and the media. No single approach is likely to be effective in addressing what is a large-scale universal problem” (p. 192).

### **Summary**

In the period from 2000 to present, professional literature in counseling and psychology has increased greatly related to suicidality amongst children and adolescents. However, it is difficult to separate – or even to know that one should separate – titles of articles that include both “children and adolescents” in recent literature. As such, there continue to be myths and misconceptions about children’s capacity for suicide, and treatment programs (if they exist within a community), may be misinformed, or based on materials that are not appropriate for children under the age of ten. At the same time, it has been acknowledged that children under age 10 can understand death, they do die by suicide at underreported rates in the United States, and that suicide attempts, plans, and ideation are quite common in childhood, and tend to increase as a child ages into pre-adolescence and adolescence.

This literature review acknowledges that children’s suicidality is a complex issue, which is affected by risk factors from multiple domains of functioning, including: biological, familial, diagnostic, developmental, social, educational, emotional, and environmental. At the same time, there are also factors amongst several domains that protect children from suicidality. Some risk and protective factors may be unique to children, who express suicidality differently than adolescent and adult counterparts, but

may be very challenging to assess due to a lack of evidence-based assessment strategies. In addition, this literature review found no standardized or best practice theory for addressing children's suicidality.

A significant gap in the literature was found, as existing studies seem to focus primarily on rates, risk factors, symptomatology, and treatment, in a quantitative investigative fashion. This excludes the qualitative and individual reaction from the children, family members, and treatment providers. As such, important voices about children's suicidality go unheard and underrepresented, which leads to ongoing stigma and myths regarding the population. Now, it is clear that researchers need to move the beyond the initial shock that children can indeed be suicidal, towards a culture that is understanding of the problem so that appropriate actions can be taken. Qualitative research on children's suicidality, especially the creation of a grounded theory, will look beyond quantitative data that expressed *that* children are affected by suicidality, to explore *how* and *why* they experience suicidality, and how practitioners might effectively intervene.

## CHAPTER THREE

### METHODOLOGY

#### **Purpose Statement**

The purpose of this study was to create a theory for understanding the phenomenon of children's suicidality 10 years of age and younger, and to indicate how children may differ from adolescents and adults who present with suicidality. This chapter on methodology will explain how the chosen research design aimed to answer the research questions regarding suicidal children. The study's context, participants, and collection of multiple data sources are discussed, and sample interview questions presented. The procedures for four rounds of data analysis are described. The author also introduces the research team that was chosen to strengthen this design, review possible biases and assumptions of the primary researcher, and present strategies taken to increase the trustworthiness of the study. Finally, the author considered possible contributions that this study may have on the field of children's suicidality research and its implications for counselors going forward.

#### **Research Design**

A qualitative design was chosen to develop a grounded theory for children aged 10 and younger who had experienced suicidality. As described in the previous chapter, it was found that most literature on children's suicidality is quantitative in nature. It had seemed logical that researchers would want to know how many children are and have been affected by suicidality and to determine the likelihood of suicide in the nation, communities, and individual families. However, a significant gap remained unexplored in the quantitative methodology. It was not enough to know *that* suicide affects children

aged 10 and younger—it was necessary to know *how* and *why* suicide affects them, so that counselors, teachers, parents and treatment providers might plan ahead to intervene and—hopefully—prevent injury and death in this young population. Hays and Singh (2012) have referred to this key characteristic of qualitative research as, “the importance of context,” and the need to “create and give meaning to social experience” (p. 6). According to Valle, Gosney, and Sinclair (2008), “Qualitative analysis of relevant data are an essential part of understanding the link between epidemiological risk factors and events leading to the death of young people to help inform effective prevention strategies” (p. 722). Unfortunately, this author discovered that qualitative research on children’s suicidality was quite sparse.

The purpose of utilizing grounded theory research was to blend elements of phenomenological and social constructivist paradigms in order to find a commonality of experiences and develop theory (in this case, for children’s suicidality) that could explain the phenomenon (Hays & Wood, 2011). Grounded theory seeks to understand phenomena that may not be well understood by creating theory that is grounded in, and formed by, data such as transcribed interviews and other written sources (Fassinger, 2005), as well as through the relationship formed with individuals who have experienced the phenomena (Charmaz, 2012). Data collection and analysis in grounded theory is an inductive, constant, and reciprocal process that funnels and focuses participants’ experiences with the phenomena towards a theory of common core experience (Corbin & Strauss, 2008). As Charmaz explained, grounded theory is designed to be *interpretive*, as opposed to *explanatory*, so that others may come to a better understanding of phenomena but not make definitive causal inferences about them. As such, the grounded theory

approach of “theorizing” is congruent with social constructivism (Charmaz, 2012, p. 128). The social constructivist, or postmodernist, paradigm is a belief system that states no one “universal truth” can be found as a research outcome. Social constructivism necessitates and values active collaboration from diverse sources, accepts that all voices are biased, and emphasizes subjectivity in knowledge creation (Hays & Singh, 2012).

Regarding childhood suicidality, this research design understands that every individual may have a different experience of any one child’s suicidality. Although one must recognize that suicidality has unlimited triggers and the solution is different for each affected child, it has become evident through research done over time that younger children do have commonalities in their presentation of suicidality that differ from their older counterparts (Ben-Yehuda et al., 2012). For this reason, the researcher chose to develop a grounded theory that would describe characteristics associated with children’s suicidality, identify the factors that influence childhood suicidality, and that would inform and help determine treatment implications for children 10 years old and younger who present with suicidality.

### **Research Questions**

Specific research questions that were addressed in this study are as follows:

1. ) What are the characteristics of suicidality in children 10 years old and younger?
- 2.) What factors influence childhood suicidality?
- 3.) What are the treatment implications for children 10 years old and younger who present with suicidality?

## **Research Plan**

To answer the research questions, the primary researcher collected data from a large, not-for-profit counseling agency for children and families in New Jersey. Data collection included 2 main components: individual interviews of treatment providers who have had experience working with children's suicidality (including any components of the suicidality spectrum – ideation, behaviors, attempts, and completions), and a content analysis of closed treatment charts for children 10 and under who had presented with suicidality before or during their treatment. These components are described more thoroughly below.

**Individual Interviews.** The researcher sought to conduct individual interviews with 10-20 treatment providers of children who have had or who were currently having suicidal ideation and behaviors. Creswell (2007) indicated that approximately 20-60 individuals should serve as an adequate sample size for grounded theory research. 12 interviews were conducted during the data collection stage. Every treatment provider participated in a semi-structured interview lasting approximately 60 minutes in order that the primary researcher could gain a depth of understanding about the spectrum of childhood suicidality, how and why it may present in children 10 and younger, and the interventions selected (e.g., assessment, diagnosis, appropriateness of modalities, and perceived outcomes). Treatment providers were also invited to identify their experiences of the gaps of current research and practice. When triangulated with data derived from treatment charts, it was determined that the researcher achieved saturation.

**Treatment Charts.** The primary researcher aimed to collect data from 20-25 closed treatment charts of suicidal children. The primary researcher spoke with the

treatment staff of the counseling agency, and specifically requested nominations, including only the alphanumeric (non-identifying) chart codes, of children 10 and younger who had previously been identified as suicidal at some point in their treatment through suicidal ideation, verbalization, behaviors, or attempts. 22 closed charts (in compliance with guidelines for grounded theory research, Creswell, 2007) were nominated and selected for review and then requested and retrieved from the on-site medical records storage room at the counseling center. Regardless of comorbid diagnoses, the primary researcher included all suicidal children in this study in order to give voice to a diverse group of children that experienced suicidal ideation and behaviors. A staff member of the agency (who was briefly trained by the primary researcher) copied the charts and masked all identifying information to maintain the children's confidentiality. The treatment charts were then only identifiable to the primary researcher through the use of codes (e.g., C001, C002, C003, etc.). Documentation regarding the suicidal children's psychiatric, social-emotional, educational, medical, and developmental histories was collected from treatment charts, and reviewed by the primary researcher. A data collection tool was utilized to standardize and organize the specific information taken from the charts (see Appendix A-5).

### **Context**

The primary researcher had a pre-existing relationship with the aforementioned counseling agency, a large non-profit agency in New Jersey that provides in-home, outpatient, and partial care services to children and families. The relationship mentioned began in January 2008 when the primary researcher was employed as a case manager for the agency's partial care programs for youth. The primary researcher's roles later

expanded to include program coordinator, individual counselor, family preservationist, intake coordinator, and outpatient and in-home therapy provider for children and families. This ongoing relationship provided regular access to the population of mentally ill children, as well as to the case managers, therapists, psychiatrists, and support staff who worked with them.

According to data from 2012, this counseling agency served 11,558 clients, including 4,526 children, in over 100 total programs for behavioral health care services. Approximately 1,400 staff members work for the agency. The agency projected they would serve approximately 2,820 total children in 2013. It was projected this would include an estimated 689 children in the outpatient counseling programs that admit children with a variety of mental health diagnoses. Treatment histories of these children were recorded and stored in individual files to which the primary researcher was given access.

The particular branches of the counseling agency from which data was derived are the children's outpatient and partial care programs. Often, (following a referral from family members or schools), the counseling agency provides the first interventions for children identified with emotional or behavioral difficulties. At other times, this outpatient facility is recommended for follow-up treatment to psychiatric hospitalization or detention/incarceration. As a result, this site is less crisis-oriented than emergency services programs or alternate sites such as area hospitals or other out-of-home services. Thus, the primary researcher speculated that treatment providers at this site might have had more complete and holistic experiences with suicidal children, more so than those who only encountered clients when they were actively suicidal as was probably the case

in, for example, the psychiatric hospitals. The counseling agency's ethics committee reviewed the overall research plan as described in this chapter and gave their permission for the primary researcher to collect data from their programs.

### **Participants**

Participants for the qualitative interviews in this study were recruited through purposive, snowball, or network sampling (Hays & Singh, 2012). The network sampling began at the aforementioned counseling agency, and branched out to also include several other individuals who were referred by employees of the counseling agency. Ontologically, the primary researcher assumed that the treatment providers were experts on suicidal clients and that they could provide interpretation of therapeutic experiences to the primary researcher. It was the primary researcher's goal to find (through purposive sampling), the most experienced treatment providers in this particular area of clinical mental health counseling, whose knowledge base of suicidality would be significant and who could speak to a variety of children's experiences. Consistent with network sampling, the first treatment providers interviewed were able to recommend others who had also worked with suicidal children, which provided a breadth and depth of experience as related to their clients' treatment to the study. The primary researcher also hoped to interview those who had had the most experience with suicidal children. To this end, the primary researcher asked interviewees about employees of other local agencies, hospitals, and schools, whom they might refer to or who could be considered "experts" in this area. It was not a necessary condition that participating treatment providers were employed by the same counseling agency.

Each participants' expertise was determined through a brief pre-interview demographic questionnaire, which asked about individuals' educational and practice backgrounds. Approximately 92 of these eligibility questionnaires were distributed to employees of the counseling agency and to those who had specifically been referred as potential participants. The primary researcher received 24 completed and returned eligibility questionnaires, including those of the final 12 eligible and interested participants, as well as 9 individuals who did not meet eligibility requirements, and 3 individuals who were eligible but not interested in participating in counseling research. Five additional individuals declined participation verbally or through email.

The final 12 selected participants held a Master's degree or higher in counseling or a closely related field (i.e., psychiatry, social work), had at least 1 year of combined treatment experience with 1 or more suicidal children aged 10 or younger, and had completed specific training in suicidality through either an academic course or professional continuing education. With these specific qualifications, the participants were able to offer information that stemmed from a depth of professional experience and training. A total of nine participants were mental health counselors employed by the counseling agency, one was a mental health counselor employed by another agency, two were school counselors, and one was a child psychiatrist. Some of the final participants had been referred by previous participants. For example, P002 referred P008, and P005 referred P009. The primary researcher ensured that the names and employers of all treatment providers interviewed were kept strictly confidential. A summary of the participants' demographics, including their training and experiential histories, can be found in Appendix B-1. Following the interviews, the data analysis included direct

quotes, narratives, and the personal perspectives of the participants, which served to provide both “thick” description (Geertz, 1973) and the participants’ individualized understanding of the phenomenon.

### **Procedures**

First, the primary researcher applied to the Institutional Review Board (IRB) of Old Dominion University in order to gain approval to perform human subjects research before starting data collection. The project was approved in December 2013 (See Appendix A-1). After gaining IRB approval, the researcher then met with the directors and ethics committee of the counseling agency in order to obtain specific written permission to work with the data collected from consumers of their agency. Upon receipt of written informed consent, the primary researcher solicited interviewee participation through a written questionnaire, set up face-to-face meetings with those individuals who were identified as suitable interviewees, provided informed consent and obtained related documentation (see Appendix A-2), collected participant demographic information (see Appendix A-3 for the blank form and Appendix B-1 for participant data), conducted semi-structured interviews of approximately one hour in length that were all video recorded (on a high definition digital recorder), and then reviewed and transcribed each participants’ responses in order to enhance thick description in data analysis. (A sample interview protocol can be found in Appendix A-4.)

Video recordings were stored on the primary researcher’s own password-protected computer only until the transcriptions were completed, and then the recordings were destroyed. After transcription, the researcher engaged in member checking by providing a written transcript along with a \$5.00 convenience store gift card to each

participant, discussing the results with the participants, and asking for their feedback including any changes or edits to their transcript. It was the intention of the primary researcher to collect participant input, including any revisions, for inclusion in the coding process. However, the participants did not provide reflections other than the comment that participants were disappointed and embarrassed at their use of vocal fillers, such as: “uhm,” “uh,” “so,” “like,” etc. None of the 12 participants made any revisions, deletions, or additions to their original transcripts.

The second part of data collection focused on client charts. Treatment providers from the counseling agency selected and nominated treatment charts of children who experienced suicidality. These charts were redacted for the primary researcher in that the child’s name (as well as the names of family members, school, town, and other identifying information), was blacked out on each document in the chart, by an agency employee instructed specifically for the task. The primary researcher then reviewed each chart in order to gather specific information including, but not be limited to, the following: age, gender, presence and severity of suicidality, methods of suicidal attempts, presence or absence of risky behaviors (e.g., head banging, running away, etc.), family constellation, socioeconomic status, race, ethnicity, religious affiliation, psychiatric diagnosis, medication profile, psychiatric hospitalizations, history of abuse/neglect, witness to domestic violence, school classification and history, service providers, and symptomatology related to suicidality (see Appendix A-5).

### **Researcher Bias/Assumptions**

Data analysis began by identifying the preconceptions of researcher bias before any data were collected. Before starting the project, the primary researcher

acknowledged insider knowledge regarding the population of suicidal children, through her role as a mental health therapist. She had personally experienced the difficulties of navigating the programs for mental health treatment with her clients in southern New Jersey, Colorado, and Virginia, including the denial that helping professionals displayed regarding the very existence of childhood suicidality. The primary researcher was (and remains) a strong advocate for at-risk children. As such, the primary researcher sought to identify and limit her own personal preconceptions and biases regarding the population prior to data collection, and as biases arose throughout the study. The treatment team was utilized to gain consensus for coding, and to review and point out how biases might have affected the quality of research. Finally, a contact summary sheet and memo was created and completed following each interview to recall, summarize, and reflect upon the research process, with the goal of minimizing threats to the study and maximizing trustworthiness.

As expected, the primary researcher found strong evidence for the presence of suicidality amongst children ages 3-10 with mental health diagnoses, within the counseling agency's children's counseling programs. This suicidality, with its wide range of presentations, significantly impacted the children's functioning across multiple domains, including: behavioral, emotional, educational, familial, social, and self-sufficiency. The primary researcher found that children under the aged 10 and younger who presented with suicidality had varied characteristics, including an array of primary mental health diagnoses, behavioral dysregulation, and emotional and environmental instability. The primary researcher also found that suicidal children often had histories of trauma that included, but was not limited to, separation from their primary caregiver and

physical, emotional, and sexual abuse. It was found that the children had had no formal training or intervention programs in their preschool or elementary school focused on the subject of suicidality or its prevention. Finally, the primary researcher expected and found that treatment providers perceived the accessibility of treatment for children's suicidality as challenging, often unavailable, and not specific to children aged 10 and younger.

The research team was utilized to develop interview protocol and a coding frame, and to analyze and interpret collected data. The research team for this study included two Ph.D. students with extensive practice in qualitative research, plus an external auditor. The first team member, who is also the primary researcher, is a biracial (Caucasian/Hispanic) female, studying Counselor Education. She holds an Educational Specialist degree in Community Counseling, and has approximately 9 years of direct experience working as a mental health counselor for at-risk and suicidal youth. The second team member is a Caucasian female, also studying Counselor Education, with a Master's degree in Counseling. This member was selected for her cognate in qualitative research and a shared research focus of suicidality. The third team member is an Asian female, studying Counselor Education, with a Master's degree in Counseling. This member was selected for her experience with qualitative research and specific work using grounded theory methodology. The external auditor was an advanced clinician, employed by the counseling agency, who monitored the primary researcher's involvement with the agency and its consumers and also reviewed the final manuscript to ensure accurate representation.

## Data Analysis

As interview data was collected, the primary researcher transcribed each recording, including both the verbal and observable non-verbal communication provided by the interviewee. When each was completed, and prior to any data analysis, the researcher shared a hard or electronic copy with the treatment provider (interviewee), to determine if they wanted to add or clarify any statements. Subsequently, the primary researcher composed a contact summary sheet (Miles & Huberman, 1994), to highlight the meaning and interpretations taken from each interview, and member checked this page also with the participants for their ongoing approval. With this completed, the primary researcher began a preliminary analysis of the data (consistent with grounded theory), and then engaged in simultaneous data collection and analysis (Charmaz, 2008), and immediately started coding data as it was received from interviews and other data collection methods.

Four rounds of coding were used in the data analysis, as described in the following paragraphs. Rounds one and two employed substantive coding, which focused on identifying new information and themes related to children's suicidality. Rounds three and four focused on theoretical coding, comparing themes until saturation was met and a theory could be created (Holton, 2007).

**Substantive Coding.** 1.) First, initial *open coding* considered that all responses from participants were valid and valuable information. Every line of text and significant words or phases in the transcription was considered in the initial phases of coding, as suggested by Glaser (1978). *In vivo* codes were identified as any significant term that the participant used to describe phenomenon related to children's suicidality. For example,

results from a preliminary study had identified children with severe physical tantrums as having “rage storms.” This phrase was not regularly found in the literature on suicidality, thus it was used as an *in vivo* code. The primary researcher engaged in this open coding process independent from the research team for the first six interviews (P001 through P006). Data was initially organized using an *a priori* codebook that was developed during a pilot study in 2011 (see Appendix A-6), and then new codes were added to the codebook, as additional information was gathered. Coding was further strengthened through use of memos and contact summary sheets, as created by the primary researcher. These documents were found to highlight important themes and quotes that stood out in individual interviews.

2.) Second, the primary researcher and both research team members completed 3 rounds of *focused coding* for interviews P007 and P008, P009 and P010, and P011 and P012. This coding involved finding chunks of data that fit together, not just words or phrases that had been identified in the first round (Charmaz, 2008). For example, after every 2 interviews, the primary researcher and both research team members independently reviewed and highlighted all material that emerged as a direct response to a research question, as an example of an early code, or “analytic category” (Charmaz, 2008, p.3). For each round, the primary researcher combined the 3 team members’ codings into one consensus-coded document, all members independently reviewed the focused coding, and then a collaboration meeting was held via Google+ to discuss the coding process and direction of the data. The primary researcher utilized the research team to also provide feedback regarding any possible misinterpretation of the data.

**Theoretical Coding.** 3.) Third, a round of *axial coding*, according to Strauss & Corbin, began the process of “bringing data back together again in a coherent whole” (1998, p. 125). While the substantive coding mentioned above served to break transcripts and other data down into essential components, the axial coding re-formed the data. Charmaz (2008) inferred that this would create the “framework” of a theory, from which core categories would emerge. The primary researcher was careful to continuously check these categories against earlier open and focused codes from the substantive coding process, and utilized the research team to discuss the theory development and potential biases. Through this ongoing process, a theory developed that was based on actual data instead of inferred (or intended) categories influenced by the researcher’s point of view.

4.) Fourth, a round of *theoretical coding* focused on theory creation and the conclusion of analysis. In this round, the core categories from axial coding were compared to one another, and organized in order to create a theory. The theory that emerged attempted to answer the primary research questions about children’s suicidality, and related directly to the characteristics of suicidal children, how younger children differ from adolescents and adults who struggle with suicidality, and the treatments that young children require to manage these feelings and behaviors.

### **Content Analysis**

After reviewing clients’ treatment charts, the researcher completed a summative content analysis (Hsieh & Shannon, 2005). This process began with frequency counting of particular keywords or content as it related to the research questions. The primary researcher charted the data and utilized the research team for consensus coding and to check for possible biases. After the research team agreed upon the codes, the primary

researcher followed with a round of interpretation to relate the data to answer the research questions. Data derived from this content analysis was triangulated with data derived from the individual interviews. Together, these data were combined to create a final codebook for informing grounded theory development.

### **Strategies For Trustworthiness**

The primary researcher designed this study to include several strategies for trustworthiness to improve the rigor and quality of the research. Four qualitative criteria of trustworthiness were targeted, including: credibility, transferability, dependability, and confirmability (Krefting, 1991). At the beginning of the research process, an audit trail was started to organize information and to provide evidence of contacts and collected data. The researcher used simultaneous data collection and analysis to shape the interviewing process. Questions on the semi-structured interviews were added and adapted after the initial interview, and as the researcher gathered data about the participant, and the topic through past participants. Data triangulation was achieved through the use of multiple sources of data, including the individual interviews with treatment providers and the treatment chart content analyses.

After data were collected, the researcher engaged in member checking with the participants of the interviews. This process included transcript reviews and discussion with the interviewees of themes that emerged from the data. After interviews, the researcher used peer debriefing within the context of the research team. Research team members were also used for consensus coding of interview transcriptions and the treatment chart data. The primary researcher considered the participants' voice as a part of grounded theory, and used it for thick description and quotations in the final report.

Finally, the auditor ensured trustworthiness by reviewing the project for adherence to the procedures and accuracy in reporting.

### **Potential Contributions**

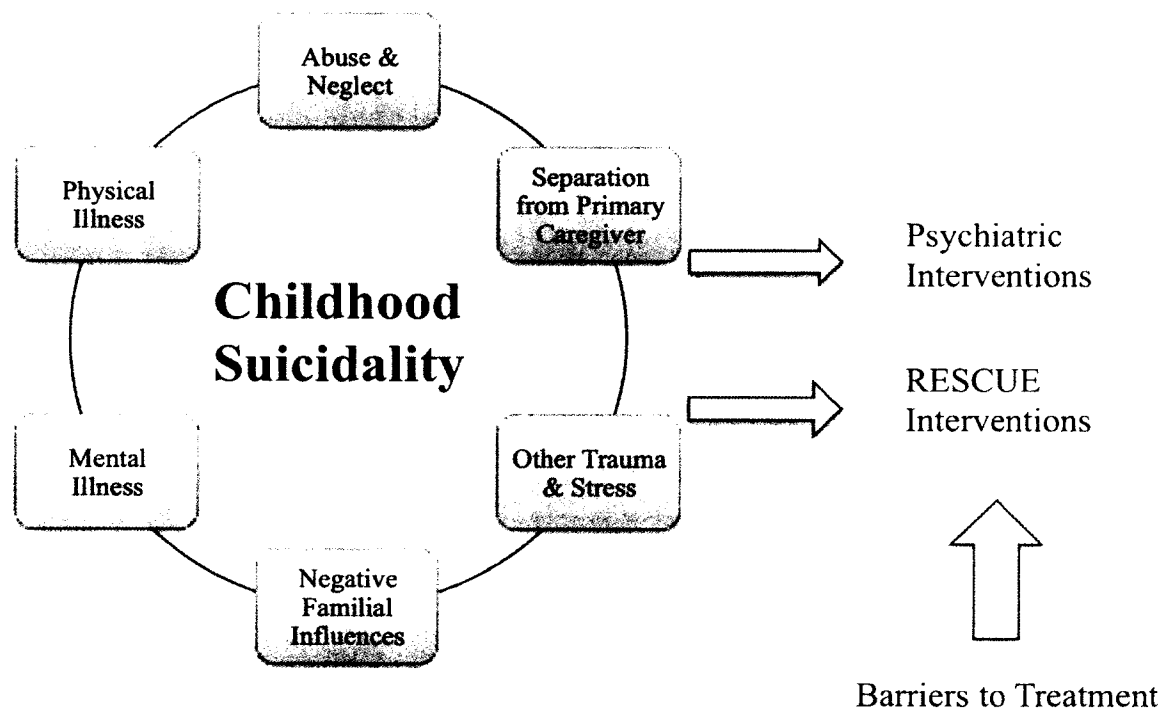
This qualitative investigation sought to add understanding to suicidality research that had historically been misunderstood as an exclusively adolescent and adult concern. The qualitative methodology was intended to add to the literature by introducing perspectives on children's suicidality that are more comprehensive than simply reporting the rates of completed suicides. This grounded theory on children's suicidality was designed to give treatment providers a deeper understanding of their younger suicidal clients, provide them with a model for engaging immediately and appropriately, and inform them of treatment implications that are more specific to children age 10 and younger.

## CHAPTER FOUR

### RESULTS

This chapter will present the findings of this study, as they pertain to the three research questions that guided the investigation. The first research question explored the characteristics of suicidality in children 10 years and younger, the second explored the factors that influence childhood suicidality, and the third explored the treatment implications for children 10 years of age and younger who present with suicidality. The author created the following figure to depict the findings of this study. It will be further described below.

Figure 1. *A Model of Childhood Suicidality*



This figure represents the theoretical and axial codes that were determined by this research to interpret the phenomenon of childhood suicidality. The most prominent

feature of this model is the core category of childhood suicidality, which is affected by six causal conditions: abuse & neglect, separation from a primary caregiver, other traumas & stressors, negative familial influences, mental illness, and physical illness. Treatment providers who encounter suicidal children are required to make choices regarding the appropriate treatments and interventions for childhood suicidality, which fall into two categories: an axial code that highlights psychiatric interventions, and a theoretical code that represents The RESCUE Model for Childhood Suicidality, which will be described in detail later in this chapter. Several barriers to treatment moderate the effectiveness of these interventions.

Regarding the core category of childhood suicidality and its symptomatology, there were 4 axial codes found, including: suicidal ideation, suicidal verbalization, suicidal behavior, and suicide attempts. Related to these axial codes were 14 open codes related to the observable qualities of suicidal children, and 7 open codes related to specific methods of suicidal behaviors and attempts in children 10 and younger. An additional 6 focused codes were determined, as related to the prevalence of childhood suicidality, children's limited understanding of the meaning or finality of death, the typical age of onset for suicidality in children, a low intent to die, a low frequency of suicide plans, and a consistent or ongoing quality to childhood suicidality.

Next, there were 6 axial codes found to be causal conditions of childhood suicidality, including abuse & neglect, separation from a primary caregiver, other trauma & stressors (including the 3 focused codes of low socioeconomic status; trauma, in general; and stress, in general), negative familial influences (including the 5 focused codes of family dysfunction, family history of mental illness, family history of substance

abuse, family history of suicidality, and parenting concerns), mental illness (including the 6 focused codes of ADHD, Adjustment Disorder, hallucinations, mood disorders, Oppositional Defiant Disorder, and PTSD), and physical illness (including the 5 open codes of poor sleep or insomnia, asthma, enuresis, ear tubes or frequent ear infections, and seasonal or environmental allergies). A final focused code, a complex interaction of triggers, was found to interpret the comorbidity of the causes of childhood suicidality.

Regarding treatment implications for childhood suicidality, this study found one axial code regarding psychiatric interventions (including the 3 focused codes of crisis screening, psychiatric hospitalization, and psychotropic medication), and one theoretical code, which introduces The RESCUE Model for Childhood Suicidality for treatment providers encountering suicidal children 10 and younger (including the six stages of intervention: Respond, Evaluate, Safety, Collaborate, Understand, and Engage). A final axial code, barriers to treatment, was found to be a mediator of treatment outcomes, and included the 5 focused codes of: the difficulty of childhood suicidality, the unavailability of assessment tools, treatment providers' sense of inexperience, ongoing myths about suicide in children, and parents as barriers to treatment.

### **Core Category of Childhood Suicidality**

This study found that childhood suicidality encompasses the spectrum of suicidality (ideation, verbalizations, behaviors, attempts, and also completions), as similar to research on adolescent and adult suicidality. The next several sections will describe the axial, focused, and open codes related to this core category of childhood suicidality, its symptomatology, and varied presentations.

**Suicidal ideation present in children 10 and younger.** Suicidal ideation affected 86.36% ( $n = 19$ ) of the study sample, including children ages 3-10. Thoughts of suicide ranged in frequency from very infrequent to frequent, as defined in Table 2 below. Presentation of suicidal ideation ranged greatly, as reported in the treatment charts. For example, C001 had frequent thoughts of death after his grandparent passed away, especially around the Christmas holiday when he stated, “I can’t wait until I die.” C019 reported that he was fearful that he would hurt himself or someone else. Many other children had frequent thoughts about their low self-worth, and would make statements such as, “I’m trash” (C004); “I hate myself, I’m stupid, I’m a loser” (C006); and “I am evil, I am going to the devil- I am never going to see God” (C008). Another child’s counselor noted that he had a “desire to constantly escape from the world he was in” (C015). Still others would display play themes that were aggressive, violent, or focused on death (C015, C016). Although different in presentation, all of these examples are representative of childhood suicidal ideation.

100% of the treatment providers interviewed reported that they had encountered suicidal ideation among the children that they serve. Two treatment providers reported that suicidal ideation was much more prevalent (around 50%) among children who had been separated from a primary caregiver (P005 and P009). P010 explained that children may have a difficult time expressing suicidal ideation to others, especially adults. He stated, “Although they may have those thoughts in their head...they’re not comfortable to tell us that right away. I think that comes through, in most cases, time and trust.”

Table 2.

*Defining Frequency Terms*

Term	Definition
Very infrequent	Occurred only on 1-2 occasions
Infrequent	Occurred on several occasions
Intermittent absence	Periods of symptomatology and periods of symptom absence
Frequent	Occurred regularly, child experienced symptoms more than 50% of the time
Very frequent	Occurred consistently, possibly multiple times per week or day, periods of remission are short or rare.

**Suicidal verbalization present in children 10 and younger.** Suicidal verbalizations were present in 90.19% ( $n = 20$ ) of the study sample, including children ages 3-10. Verbalizations of suicide ranged in frequency from very infrequent to frequent, as defined in Table 2. Exact statements related to suicide varied greatly, as reported in the treatment charts. For example, some children reported directly, "I want to die," (C007) or "I want to kill myself" (C006), while other children made comments which were more vague such as, "I wish I wasn't born" (C009), "I don't want to be here anymore" (C017), or "I want to starve" (C020). Some children verbalized specific actions that they would take to end their lives. These statements described actions that may have been feasible for the child to act upon, such as: jumping off a banister, setting skin on fire, or jumping off a roof (C016); while other statements were more outlandish,

such as: I'm going to "get a cop's gun and shoot myself" (C001). Several treatment charts described children who made suicidal verbalizations during tantrums or when feeling angry or upset, and one chart in particular noted that the child later recanted his statement when he was feeling calmer (C014).

Many treatment providers interviewed described incidents of suicidal verbalization when working with children. P003 described the age that children seem to first verbalize suicidality, and she stated: "Four [years old] is when they might start saying something like they want to die or they want to kill themselves." She went on to say:

So it's kind of the first- they're kind of experimenting with [verbalization] like, "What are they going to do if I say I want to kill myself? What are they gonna- like what's going to be the reaction to that? What's going to happen?"

In addition, several participants recognized a tendency for children (and adults) to misuse language to express negative feelings as in slang expressions, which have become cliché.

P002 stated:

In those cases, it tends to be more of a statement of frustration. ...Yknow, I think we all say inappropriate things when we're angry or upset, and just, "Oh, God, I could kill myself! Kill me!" Or something like that.

P007 stated:

There are also times when you'll say, (As counselor to child.) "Well, you said that you wanted to hurt yourself. Do you still feel that way?" (As child.) "No! I was just in a bad mood that day. I'm- I'm- (Makes "pfft" sound.) I'm fine now. I was just upset. I was upset about my math test. And I said that. I didn't really mean

that.” And you can follow up. (As counselor to child.) “Well, you understand that because people are concerned about you, they do want to make sure that you’re okay. And so if you’re telling me that you’re really okay, you’re not thinking about hurting yourself in any way...” (As child.) “No, no, I’m- I’m really okay, I’m- bad day, bad moment, everything’s good now.” (Returns to normal voice.) Uhm, usually- I mean, in my experience, they have been accurate of their description in either thing.

P004 added, “It’s tough because there are the population of kids who cry wolf and that kind of creates the idea in the system that they don’t need help.” Whereas some children might be experimenting with their words for the first time, or learning to effectively and accurately express their emotions, other children may make verbal suicidal threats that are very specific and intentional, with feasible plans to cause their death. P005 explained that verbalizations should be considered a warning sign for future suicidal behaviors.

P009 recalled one such serious incident, and she stated:

[He] stated it, and he ran across the street. He said it, and he ran...didn’t matter that cars were there. He uh just...we were in [name of town], he was at the top of the stairs, he ran down there, and we’re all standing there going, “One of us has to go get him!”...But in that moment he was so distressed, we just needed- he needed to have that hurt go away somehow. And he repeated more than once that he wanted to kill himself. But he was four. And that was the first time I had ever heard a l- a child that age- a pre-K, I mean, say that he wanted to die.

While suicidal verbalizations may not necessarily represent an intention to die, the absence of suicidal verbalizations does not mean that a child will not have suicidal

thoughts or behaviors. P002 stated, “They can be suicidal without saying those things...” P003 recalled an incident with a 5-year-old female who severely scratched her own skin, and reported, “she never really said anything.” For example, C005 had no history of suicidal verbalizations, but she did demonstrate frequent suicidal behaviors, such as biting herself, pulling her hair, severely scratching her skin, and one incident of self-poisoning in which she sprayed a toxic household cleaner on her food. Similarly, C022 did not verbalize suicidality, but he did experience significant suicidal ideation, which led to two psychiatric hospitalizations. Overt warning signs of children’s suicidality may be limited or even absent.

**Suicidal behaviors present in children 10 and younger.** Suicidal behaviors were present in 86.36% ( $n = 19$ ) of the study sample, including children ages 3-10. Suicidal behaviors ranged in frequency from very infrequent to very frequent, as defined in Table 2. Exact behaviors related to suicide varied greatly, as reported in the treatment charts. Some children made suicidal gestures, such as putting a knife to their throat (C001, C009, C018, C019), or putting a belt around their neck (C003, C019). Others engaged in risky behaviors, such as running out into a street or parking lot (C003, C004). Still others engaged in deliberate self-harming behaviors which also ranged in lethality, such as: biting oneself (C002, C003, C005, C006, C010, C016, C017, C021), head banging (C001, C006, C007, C010, C011), and vaginal mutilation (C012). P009 also described C012 in her interview:

There was a little girl who, initials XX [omitted], she actually...she actually uhm disfigured her- her body vaginally after she had been sexually assaulted. Uhm, under the age of ten. She was another one. She did not like herself. And she had

been threatened to be killed by her mother when she was three. So, her mom- her mom had put a knife up to her throat. So, uhm, if your body is all you have...and you don't want it around, and you don't have all the words or the supports or they've learned how to cope. (Shrugs shoulders.)

This study found that treatment providers were often unable to distinguish suicidal behaviors and attempts. It seemed that some suicidal behaviors were so lethal, that they might be considered a suicide attempt. When asked to distinguish the two, P004, a child psychiatrist, stated:

I think it's really hard to differentiate. And I think it's in part because yknow, it's hard for us as adults to communicate with kids in a way that's effective...uhm, to really understand what's going on in their head. So...I think it's really tough.

100% of the treatment providers interviewed reported that they had encountered suicidal behaviors among the children that they serve. Several of the treatment providers (P002, P005, P008, P010, P011) suggested that children may engage in suicidal behaviors – as opposed to talking about them – due to their lack of verbal abilities. P010 stated:

I think with children uh...you know, I think a lot of times with them, they're probably not able to express how they're really feeling in- in appropriate words...they may not have the ability to express themselves appropriately. So, it's going to come out, so they do it the best way they can. "Hey, if this is what it's going to take for you to notice me, uhm, then this is what I'm going to do." But I think that's the biggest part- the biggest difference [between suicidal children and adolescents or adults] is just not having the vocabulary or the tools necessary to- to tell me what you really need and what's going on.

P008 related a story about a particular suicidal child that she worked with, and stated:

I one time had a little girl who the teacher sent the child to me because she had cut herself on her wrists with razor blades. And when I said, “Honey,” yknow, “what happened?” She said, “I wanted to go to heaven.” ...It was very clear what she told me. And she was such a young child... and the problem with such young children is...there might be an action, and there might be intent, but they can’t always explain what leads to it, and that’s what makes it so vague, because not all children that young have the words and the mechanisms to really make it clear why they’re hurting. And so they may be more apt to- to do something to themselves, and then really understanding what’s behind it is hard.

Several participants (P005, P006, P008, P009, P011) also considered intentionally poor self-care as a form of suicidal behavior. For example, P009 stated, “If you’re just not going to eat...if you’re just going to simply refuse- not to eat, not to bathe, not to do anything self-care related, and you’re not even ten.” P009, who has worked extensively with infants, noted that changes in toileting habits could also represent suicidal behaviors: “You’ll see that they will uhm *sit* in wherever they have soiled, so they can’t sleep, or their body becomes even more uncomfortable.”

**Suicidal attempts present in children 10 and younger.** Suicidal attempts were present in 31.82% ( $n = 7$ ) of the study sample, including children ages 3-9. This indicates that suicide attempts were the least frequently occurring form of suicidality in this sample. Suicidal attempts ranged in number from 1 attempt (C008, C011, C017, C018); 2 attempts (C013); 3 or more attempts (C001, engaged in at least 6 attempts); and one chart had an unknown number of attempts. In this case, the “attempts” were defined

by the authors of the treatment charts, and not the researcher. Exact methods related to suicide attempts varied greatly, as reported in the treatment charts, and there were few duplications in method.

83.33% ( $n = 10$ ) of treatment providers interviewed had encountered suicidal attempts by the children that they served. (In addition, only one treatment provider, P006, a counselor and former nurse, had worked with children that died by suicide.) P004 stated, "It's a rare thing to have...yknow, a kid under 10 actually have an attempt...I would say it's more like the 12, 13, and up..." Although less frequent than the other forms on the spectrum of suicidality, children do engage in suicidal attempts. P002 described a suicidal attempt of one of her clients in particular: "This one eight year old boy, yknow, stuck his head in an oven and tried to turn it on and when that wasn't working, he put his head in a microwave and tried to turn that on." P011 also described a strangulation suicide attempt of one of her clients:

Kids will do that, they'll like try to (Puts both hands around neck to demonstrate choking.) ...I've seen that a lot. Little guys do that. And I think a parent wouldn't- would brush it off. I had one kid actually did it on the school bus, tried to kill herself on the school bus...by cutting off the oxygen. ...These kids are intentionally, by themselves, trying to kill themselves. ...It's not like a sexual thing, it's not even a play thing among peers, this is by themselves, "I want to die." (Puts both hands around neck again, to demonstrate.) And that's their intention, and they'll even tell you, "That's what I was trying to do."

P006 worked in a hospital setting with chronically ill children and several children who died by suicide. She stated:

It was really uhm children that were chronically ill that then didn't take their medication and ended up being hospitalized. Like, it was like they had a loaded gun. ...[Diabetic children] don't have to do anything more than eat a ton of sugar, not take their insulin, uhm- it's giving them permission to do what they have to do, knowing why they're doing it. ...And they purposely yknow, would change the medication around so as they would die. Yknow, or make the attempt.

**Observable qualities of suicidal children.** Children who are suicidal may display a wide variety of behaviors and emotions, as evidenced by the 52 unique characteristics found in children's treatment charts. To adults, many of these symptoms may not seem out of the range of expectation for the typical child. In truth, all children experience the occasional tantrum, irritable moment, or crying spell, and most will not experience suicidality. However, this study found 16 observable qualities that were frequently present in suicidal children and may be considered warning signs for childhood suicidality. These 16 qualities were determined by frequency counting in the content analysis and through consensus coding with the research team. For example, "rage" was one of the 52 characteristics noted in the treatment chart of C001 (or 4.76%,  $n = 1$ , of the sample). This code was omitted from the final 16 observable qualities due to its low frequency and because other characteristics better represented childhood suicidality, such as "aggression" (66.67%,  $n = 14$ , of the sample). P001 explained the importance of interpreting warning signs of suicidality in children:

I think some kids who have been suicidal are often viewed as like behavior issues - kids with behavior problems. And I think they're also - they're usually addressed in that way. Uhm so, and I think sometimes because of that people don't look

kinda beneath in - as to what's going on. So I think they do need some sort of education about like what this all means and how it all fits together.

The 16 observable qualities are reported in Table 3 and subsequently described individually below.

Table 3.

*Most Frequent Observable Qualities of Suicidal Children*

Quality	<i>n</i>	Percentage	Interview Agreement
Impulsivity	16	76.19%	10
Crying or sadness	15	71.43%	5
Homicidal ideation, threats, or behaviors	14	66.67%	7
Aggression	14	66.67%	4
Mood swings or labile mood	10	47.62%	4
Poor social/communication skills	9	42.86%	4
Running away or elopement	9	42.86%	3
Oppositional defiance	9	42.86%	2
Irritability	8	38.10%	1
Tantrums	7	33.33%	6
Isolation or seems withdrawn	7	33.33%	1
Urination in inappropriate places	7	33.33%	1
Stealing or theft	7	33.33%	0
Low self-esteem	5	23.81%	4
Risky behaviors *	--	----	7
Poor self-care *	--	----	5
Attention-seeking is incorrect assumption	3	13.64%	4

*Note.* *n* = Number of treatment charts that included the code. The asterisk (\*) denotes that this code derived from interview data, for which statistics were not available.

***Impulsivity.*** Impulsivity was reported in the treatment charts of 76.19% ( $n = 16$ ) of the suicidal children in this study. It was also discussed in 10 of 12 interviews with treatment providers. P001 described impulsivity as a significant early warning sign: “The first thing I tend to see with kids who are suicidal is an increase in impulsivity.” P001 also described impulsivity as one of the most potentially deadly characteristics of a suicidal child: “The more impulsive a child is, the more likely they are to do something that might put their life at risk.” P004 stated, “You’ve got a kid who says, ‘I want to kill myself,’ and they’re really impulsive then, yknow even if they mean to or not, things can happen, yknow if an opportunity presents itself.”

***Crying or sadness.*** Crying and/or frequent bouts of sadness was reported in the treatment charts of 71.43% ( $n = 15$ ) of the suicidal children in this study. It was also discussed in 5 of 12 interviews with treatment providers. In addition to directly observing a child cry, P005 described that sadness might also be represented in children’s artwork. He stated: “Dark colors were something that we always looked out for. Not just for suicidality, but for sadness, depression in general.” At the same time, P007 cautioned that suicidal children may not always appear sad. She stated:

I think – in my experience – what I see to be the biggest difference is that often, elementary-aged kids will uhm, act out in angry ways, rather than be exceptionally tearful, or sad, or appear to be in despair. So, it may come as a surprise at times, when it might be a child such as that who then also expresses these- these [suicidal] ideations because I think adults who maybe don’t have the same type of training, expect it to be someone who *looks sad*.

***Homicidal ideation, threats, or behaviors.*** Homicidality was reported in the treatment charts of 66.67% ( $n = 14$ ) of the suicidal children in this study. Homicidality was observed on a spectrum, which ranged from vague homicidal ideation and threats when a child was angry (C001, C003, C007, C017, C018, C019, C022), to very specific threats while wielding weapons (C009, C010, C015, C019), to serious physical assault and homicide attempts (C002, C005, C009, C010, C011). Some of the children's homicide attempts were incredibly dangerous and life-threatening. For example, C009 wrapped bubble wrap around his brother's neck and tried to strangle him; C016 attempted to burn his house down (he had turned the stove on, played with lighters, and manipulated an electrical cord in order to set fires, which he succeeded in doing on multiple occasions); and C010 assaulted a boy so badly at soccer practice that the boy required medical attention and missed school for a week due to his injury.

The correlation of homicidality and suicidality was discussed in 7 out of 12 participant interviews. P011 reported that the single most powerful experience that she had with a suicidal child also involved homicidality. She described the incident with this 9 year old female, and stated:

The foster mom called me, uhm and told me that uhm she was threatening to kill her and threatening to- after she was going to kill her, she was going to run into traffic and kill herself. And she was running around the neighborhood, like out front of- in the street, when I was on the phone with her. So that was terrifying because I'm on the phone.

In addition to homicidality, P009 explained that there is a strong correlation among suicide, homicide, and animal abuse. She described one girl in particular who – on

separate occasions – ran in front of traffic as a suicide attempt, had threatened to slice the throat of her foster sister, and had also banged her pet gerbil repeatedly on a table. P009 also stated, “I don’t know the line between suicidal ideations, homicidal ideations, injuries to self, injuries to animals – they seem to be related!” Some of the children whose treatment charts were examined also exhibited all of these behaviors. For example, C002 threatened to bring a gun to school and “shoot everybody,” on another occasion cut his brother with a knife and threatened to cut his cousin, and it was also reported that the child had abused the family cat.

***Aggression.*** Aggression was reported in the treatment charts of 66.67% ( $n = 14$ ) of the suicidal children in this study. It was also discussed in 4 of 12 interviews with treatment providers. Some examples of aggressive behaviors included: throwing chairs (C001, C002, C007, C011), hitting or kicking others (C002, C007, C014, C020), using aggressive language or cursing (C007, C014), and being aggressive with pets (C010, C021). Regarding the nature of his aggressive behaviors, one mother reportedly called her son, “a ticking time bomb.” The combination of suicidality and aggression was often cited as a reason for hospital admission (aggression was clearly reported in 8 out of the total of 25 psychiatric hospitalizations found in the content analysis, and specifically pertained to C001, C003, C011, and C022).

P009 also described how aggression could be demonstrated in themes of children’s play. She stated:

By the time I met this little guy, he was four, he was pretty much not verbal at all whatsoever. But what he used to do is he would take all of his toys- dolls- I’m sorry, not all the toys- he would fill a jug- a bin of water, and he would hold each

one under the water for an extended period of time. Now, in the beginning it looked like water play, yknow? ... Well, when you take that kind of water play and you compare it to a child in an early childhood center... , for example, like when I was doing my grad study, those are these kids that are not exposed to as persistent trauma. Water play may be much more imaginative and exploratory in a much more traditional way. But this little guy really looked like he was symbol- he was reenacting or symbolizing some sort of behavior that was harmful. It was- it would promote death.

***Mood swings or labile mood.*** Mood swings or a labile mood was reported in the treatment charts of 47.62% ( $n = 10$ ) of the suicidal children in this study. It was also discussed in 4 of 12 interviews with treatment providers. P001 described suicidal children's moods as variable, including nervousness, irritability, and frustration. He also described that children tend to have a low emotional awareness. He stated, "They might not understand that they're sad or upset or angry, yknow, or frustrated. They don't have, I think, the skills sometimes to do that."

P003 noted that suicidal children tend to "have a really hard time calming down." Mood lability was also cited as a reason for several of C001's psychiatric hospitalizations.

P007, a school counselor, stated that she became familiar with several students with mood lability prior to their demonstrating suicidality. She stated:

Whether behaviorally, they might have had emotional outbursts, they had perhaps some peer issues. Uhm, increased emotionality, unstable mood swings. So, they weren't unfamiliar people. In fact, I don't think I've ever had a student that we've had this concern for that I didn't know prior to making an outside referral.

***Poor social or communication skills.*** Poor social or communication skills were reported in the treatment charts of 42.86% ( $n = 9$ ) of the suicidal children in this study. Poor social or communication skills were also discussed in 4 of 12 interviews with treatment providers. P006 stated that poor eye contact was reported as one of the more observable characteristics of poor social skills, and this was also observed in 9.52% ( $n = 2$ ) of the treatment charts. Bullying has been cited in pop culture as significantly affecting children's socialization, and has also been linked to suicidality. P007, a school counselor and anti-bullying specialist, explained that bullying did not seem to specifically trigger suicidality in the elementary school population that she served. (P008, another school counselor, agreed that bullying is not a significant trigger of suicidality in the elementary population.) Instead, P007 described how poor social skills resulted in disappointing peer interactions. She stated:

In other words, the kid who's expressing this suicidal ideation can often be the same kid who's very provocative to other kids. So, it's not so much that they are actively being rejected or kind of shunned, but they make a social relationship difficult because they can *be* difficult. At the same time, they can be very hypersensitive to what other kids are doing. In other words, uhm, really thinking that every behavior of the other child is designed either to thwart them, or because they don't like them, or they're very mistrustful of their interactions with other kids. So, in my experience, if the other kids pull away from them, it's more because of some of the things that they unknowingly are putting out there. We call them "friendship repellers." We talk about things that attract friends and things that push them away. And we use magnets to kind of demonstrate the

difference – like magnets that come together and magnets that you kind of have to force together – to talk about those types of behaviors. So, often these kids will be doing things that really are off-putting to other kids, but have a very hard time understanding how what they might be putting out there is causing other people to respond to them.

***Running away or elopement.*** Running away, also called “elopement,” was reported in the treatment charts of 42.86% ( $n = 9$ ) of the suicidal children in this study. Five of the children were reported to have run away from home (C001, C009, C010, C011, C021), while others ran from a program (C003), and one from multiple settings (C001). Generally speaking, the children did not run far away from home or stay away for more than 1 to 2 hours. The frequency of the behavior was not always reported in the treatment charts, but one child in particular (C011) ran away from home 2 to 3 times per week, went to the end of the street, and then returned home without adult intervention.

Running away or elopement was also discussed in 3 of 12 interviews with treatment providers. P007 stated:

Sometimes we'll [observe suicidality] with kids who are also flight risks. ...They will run...away from you, out of the building...anywhere, away. ...We've all be trained in restraint and things like that and some of these [suicidal] kids are the kids that I would have to restrain and keep from- in one particular case in running out the front doors of the school, which kind of led- (Gestures toward the windows and outside.) it was a road similar to this...So, basically if the child did (Gestures with hand “take off” or “run.”) they would have been out. *Interviewer:*

*They would have run out in front of traffic or something like that.* P007: Right.

Yeah. (Nods head.)

P003 described one preschool-aged child's frequent elopement attempts from a partial care program. She stated:

We had one kid who ran out of- who would run out of the room and try to jump over the fence. And we asked him why he wanted to jump over the fence and he said it was because he needed to go in the dumpster. Because he was trash.

P008 described a 1<sup>st</sup> grade female student who tried to run away from a moving car. She stated:

She was not at my school the day uhm that she threatened to commit suicide. Or, actually tried to jump out of a car, but she was my student following that. But strangely, I was in her school that day in a meeting, and I could hear her screaming, and I had known her prior...and I knew who it was that was having like- kind of like a tantrum at that point, and it wasn't until a few months later that I learned that she had been- really having like that type of acting out that day. ...So then, monitoring her after the fact for two years was kind of... That's a child that really weighed heavily on my mind. *Interviewer: Mhmm. And she wanted to jump out of a car? She tried to jump out of a car?* P008: She tried. She actively tried to jump out of the car. Because she was in trouble and she didn't want to have to deal with the consequences of that.

***Oppositional defiance.*** Oppositional defiance was reported in the treatment charts of 42.86% ( $n = 9$ ) of the suicidal children in this study. This figure includes both a formal diagnosis of Oppositional Defiant Disorder ( $n = 6$ ), and reports of oppositional

defiant behavior ( $n = 9$ ), as recorded in the treatment charts. Oppositional defiance was also discussed in 2 of 12 interviews with treatment providers. P011 described oppositional defiance as a significant characteristic of children's suicidality. She stated:

I would say they've all kind of been different in how they- [presented] but most of it is like they a- they act out oppositionally. So, they're a behavior problem for the parents. Like, I would say that's all of them. That's how they are like acting out. And the parents are like yknow, "You need to stop that behavior."

But...yeah.

Later in the interview, P011 went on to explain that oppositional defiance is a behavior that might mask deeper emotional issues. She stated:

They fit the criteria of what Oppositional Defiance Disorder is, but I think how you...re- look at it. Like, okay it's oppositional defiance. Is it just a matter of they're quote unquote a bad kid and they need more rules and they need to be punished because they're acting out? Or do you need to understand the back-story about why they became the way that they are and understanding that and then working with that.

***Irritability.*** Irritability was reported in the treatment charts of 38.10% ( $n = 8$ ) of the suicidal children in this study. It was also discussed in 1 of 12 interviews with treatment providers.

***Tantrums.*** Tantrums were reported in the treatment charts of 33.33% ( $n = 7$ ) of the suicidal children in this study. Tantrums were also discussed in 6 of 12 interviews with treatment providers. P001 described that tantrums may indicate a time of increased risk for childhood suicidality. He stated, "But, with kids it's been – it usually is at the-

like during a tantrum or something like that. And they're usually having some kind of explosive episode and that's usually when it will occur."

***Isolation or seeming withdrawn.*** Isolation or seeming withdrawn was reported in the treatment charts of 33.33% ( $n = 7$ ) of the suicidal children in this study. It was also discussed in 1 of 12 interviews with treatment providers. P001 described how it may be challenging to evaluate isolation in young children. He stated:

They're also at a different place with social development, too. And I think, teens a lot of times, when I work with them, it's yknow, that's one of the red flags is feeling separateness from others and isolation and all that. And, with kids again, they're in a different place socially so it's a little bit harder, I think, to identify sometimes within kids because there aren't all those - The telltale signs that we look for in suicidality are really modeled after, I think, teens and adults. And so, when you're looking at kids, again them being in a different developmental stage, that really changes the game a little bit.

***Urination in inappropriate places.*** Urination in inappropriate places was reported in the treatment charts of 33.33% ( $n = 7$ ) of the suicidal children in this study. The content analysis showed that 5 children intentionally urinated on the floor (C002, C003, C008, C010, C014), 2 children attempted to urinate on other people (C003, C004), and 1 child urinated in the family pet's food and water bowls. Urination in inappropriate places was also discussed in 1 of 12 interviews with treatment providers. P003 described an incident with a preschool-aged child who had previously been diagnosed with suicidal ideation. She stated:

So he came in, really had a lot of problems, and uhm there was at one point in time he was- he peed on me at one point in time. It was really gross. (Smiles and laughs.) ...Like purposefully. Like- not like, "Oh I had an accident!" ...No, he took it out. He didn't pee on himself at all actually. He like took it out and like peed on me. He was sitting next to me...Yeah. It was pretty awful.

Three of the children who urinated in inappropriate places had histories of defecating in inappropriate places and smearing feces, as well.

***Stealing or theft.*** Stealing or theft was reported in the treatment charts of 33.33% ( $n = 7$ ) of the suicidal children in this study. It was not discussed in the interviews with treatment providers.

***Low self-esteem.*** Low self-esteem was reported in the treatment charts of 23.81% ( $n = 5$ ) of the suicidal children in this study. For example, several children made verbalizations such as, "I'm bad" (C010, C013, C020), "I'm stupid, ugly, evil, and not good enough" (C011), "I'm unwanted" (C013), and "I don't deserve to be happy" (C020). The theme of low self-esteem was also discussed in 4 of 12 interviews with treatment providers. P003 observed in one child that suicidality was a part of a cycle. She provided an example of a preschool-aged child:

So he makes all these bad choices because he's so impulsive, and he feels really bad about them, but instead of saying that he feels really bad about them, he just makes more bad choices. ...Uhm, and I think that that all like rolls into then feeling really bad about himself – suicidal ideation, wanting to hurt himself, wanting to hurt the people around him because they can't read his mind.

P007 explained that low self-esteem was often evident in children's writing assignments at school. She stated:

Uhm, especially in the- I'd say like 3<sup>rd</sup>, 4<sup>th</sup>, and 5<sup>th</sup> grade, where they may have a daily journal prompt, or a daily writing piece, and they might be given a topic to write about. Or they might be asked to reflect on something that they've read. Uhm, on one particular occasion, it happened to be a note that had been written that was in a writing folder. So, it wasn't something that was part of an assignment, but just happened to be in a place where someone would see it, and find it, and- and be concerned about what was written. Typically, things along the lines of, "I'm not worth anything," or, "I hate myself," or, "I don't have any friends," or expressing extreme loneliness, or uhm... "Everyone hates me," or uh...something about how they get along with their families. Those are often the things that we would see in the writings.

***Risky behaviors.*** Risky behaviors were not specifically mentioned as a characteristic related to suicidality in the children's treatment charts, but were discussed in 7 of 12 interviews with treatment providers. Many of the behaviors listed in the treatment charts might also be considered risky, such as: having access to lethal means of suicide (23.81%; C002, C009, C015, C016, and C021); posing a fire risk (14.29%; C010, C016, C021); throwing oneself on the ground (13.64%; C006, C008, C014); or eating dirt (4.76%; C003). The interview participants also named and described several risky behaviors. For example, P010 stated: "There was a lot of things he would do that we would consider to be dangerous. Whether it was throwing chairs through the windows,

you know, those type of things.” P011 described the risky behaviors of one 9 year old female:

She would chew all of her fingernails to the point where she would bleed. She would shut down, she would just go under the table and not talk, hide, uhm try to lock herself in the bedroom, the bathroom. Uhm, run out into traffic. Yeah. And just be defiant, like instigate, be mean to the foster mom.

P012 discussed that risky behaviors related to suicidality may be evident in children’s play themes. She described a warning sign when using a dollhouse or sand tray intervention, “when they’re pretending to be themselves and they’re like violent towards themselves,” and gave an example, “They’re gonna jump off a house...”

P006 described how children might gain a sense of control when adults react strongly to risky behaviors. She stated:

So, I think very young children are more vulnerable because uhm when they see a reaction if they do something risky, they see a reaction now they’re in control. They’re in control of sometimes very horrible situations. And even if they’re not sick. Yknow, you’ve gotta worry when you see a child- (Uses a firm voice and has a self-assured expression on face.) “Guess what? I can do this. You can’t stop me!” (Returns to regular voice and expression.) Yknow? And even a young child, especially the impulsive kid, the kid who has a short attention span, the one who’s like jumping all over the place, and they’re going to show you who’s in charge. And they’re going to show you they are in control of them. And uhm...it depends on the personality. It depends on- especially the impulsive kid, the one that is uhm- takes risks. Yknow, risky risky kids. Like those are the ones you

gotta worry about. Uhm, ones that will- a recent one we had where he would yknow, look for knives and like turn on the fire, and yknow like, “I’m gonna...” And one boy, another boy, that was uhm a few years back, who’d say, “I’m gonna fire me.” And he’d put himself on fire.

**Poor self-care.** Poor self-care is a characteristic that was not specifically reported in the children’s treatment charts, but was discussed in 5 of 12 interviews with treatment providers. As discussed previously, P009 not only stated that poor self-care is a characteristic related to suicidality, but she went as far as to say that poor self-care (e.g., sitting in a soiled diaper to the point of physical discomfort; food refusal; intentionally poor hygiene) is actually a suicidal behavior. P006, who formerly served as a pediatric nurse, described how intentionally poor self-care for medically fragile children could also be considered suicidal behavior. She stated:

The young young ones were like, “Today is all that matters.” (Laughs.) Yknow? But then they could be at-risk, too! I mean, uhm, kids who are on dialysis pulling out their access during dialysis. That’s certainly yknow, a risky thing. And just because they’re totally fed up.

**Attention-seeking is an incorrect assumption.** Attention-seeking was reported in the treatment charts of only 13.64% ( $n = 3$ ) of the suicidal children in this study, and oppositely, attention-seeking was not reported in 86.36% of the treatment charts. In fact, 4 of 12 interviews with treatment providers showed the theme of attention-seeking as an incorrect assumption about suicidal children. P002 described that about half of the parents of suicidal children she had worked with may incorrectly assume that their child is acting out for attention. She stated:

It's usually because their child has been acting out for a long time and they just think, "Okay, like I've had enough of this and I want- I want my child to start behaving correctly." And they don't necessarily feel...Feel that the child is suicidal...Just that yknow, he's trying to get attention, really...something like that.

P007 acknowledged that children do sometimes make suicidal verbalizations to gain adult attention. She stated:

We've had kids in the past who...that that might be kind of their go-to thing to say because it- whatever else is going on, it stops it immediately. And I get that, yknow. And with some kids you may hear that more often than not.

Then, P007 went on to say that the frequency of this type of attention-seeking was low.

She stated that this applies to:

A small percentage. I mean, in fact, I can think of maybe 2 kids that I've worked with where...(Throws hands up in the air.) They would kind of send up that flair. ...And it's usually in a situation where that child has just done something they...absolutely should not have done under any circumstance, and then it's follow with... *Interviewer: And then they draw that attention, and you forget what they did wrong.* P007: Right. (Nods head.) Right.

P005 described how other children might have a great deal of seriousness in their suicidality. He stated:

I think with some of the kids they were in such pain that they wanted- they wanted to hurt themselves. It wasn't just attention because there were a lot of things our kids could do to get attention. Uhm, saying, "I wanna die," yknow,

that- they knew immediately would get taken to crisis and a lot of them would struggle to go there. I really- looking back, I really did get the impression that it wasn't just attention-seeking behavior. (Shakes head no.) I think there was some truth to it. I don't think they really fully understand the uhm finality of it all, but I definitely think there was some type of- there was a lot of pain there that would cause them to want something more than just to cut themselves, hurt themselves, but yknow, life wasn't fun for them.

**Most frequent methods of suicidal behaviors and attempts.** There were 19 unique suicidal behaviors recorded in the treatment charts, and 8 unique suicide attempt methods. Although the methods of suicidal behaviors and attempts ranged, several of the codes shared commonalities and sometimes overlapped. An example of overlap can be seen in the code "choking self," which was recorded both as a suicidal behavior for C006, and a suicidal attempt for C008 and C017. Similarly, "cutting or scratching skin" was another overlapping code. P006 described difficulty in defining suicidal behaviors, and stated:

This is hard, you know, because it depends on what you call suicide. I mean, sometimes children will do things that result in death. I don't know that I would say uhm if you're- if that's how you're describing suicide?

One might speculate that non-fatal cutting on one's arm might be considered a suicidal behavior, whereas deep cuts or stabs could be considered a suicidal attempt, due to the difference in lethality. The treatment charts did not provide sufficient detail for the researcher to understand the level of severity or extent of the suicidal behaviors or attempts. Combined with the interview participants' reported difficulty in distinguishing

self-harming behaviors as either a suicidal behavior or a suicide attempt, the research team did not wish to separate the codes in reporting. Therefore, the most frequent methods of suicidal behavior and suicide attempts for children ten and younger are combined in Table 4 below.

Table 4.

*Most Frequent Methods of Suicidal Behaviors and Attempts*

Code	<i>n</i>	Percent of sample
Cutting, stabbing, or self-mutilation	10	45.45%
Biting self	8	36.36%
Choking, strangulation, or suffocation	7	31.82%
Hair pulling	6	27.27%
Hitting, kicking, smacking, or punching self	6	27.27%
Head banging	5	22.73%
Trying to get hit by a car	5	22.73%

*Note.* *n* = Number of treatment charts that included the code.

**Prevalence.** Interviews with treatment providers provided varied estimates of the prevalence of childhood suicidality, which ranged from less than 1% (P004, P007, P008, and P012) to approximately 50% of the population that the treatment provider served (P005 and P009). With the exception of two treatment providers who served severely mentally ill children in out-of-home treatment settings, the seemingly agreed-upon estimated range of the prevalence rate of childhood suicidality was between less than 1% and 10% of the general population (P001, P002, P003, P004, P006, P007, P008, P012).

P005 distinguished the prevalence rate of childhood suicidality by the spectrum of suicidality and its lethality:

I'd say 20 per- 15 percent to 20 percent had expressed some- had said it. Of that percentage, how many would I say really had an intent or a strong desire? Uhm, I would say maybe 5 percent. ...I would guess that every...kid at some- a good majority of every- of the population I work with, have thought about suicide at one point. Zero through 10, maybe slightly under 50%.

One participant, P010, noted that childhood suicidality is a growing issue, and stated, "It's not going to go away any- anytime soon." P004 discussed how adults may be unaware of the true prevalence rate of childhood suicidality. She stated, "I think that we probably don't do a very good job of asking about it in younger kids. I mean, that's the bottom line." She also spoke to potential misdiagnosis of children's suicidality in emergency room settings: "I think it's so hard because a lot come through the ER and might get written up as an accidental overdose or something – accidental ingestion – and get discharged and we don't ever see that." P001 stated, "I would say it's probably a larger issue that people really understand, for sure."

Also regarding the prevalence rate, P002 stated: "I feel like when you're talking about kids that are suicidal, any number is a lot." In addition, P006 echoed concern about the prevalence rate, and stated:

I think numbers are deceiving. Even if you say like, 'Look, with a 3 year old it's only 5 percent,' or whatever, even if you were to say that, they're not logical. So those 5% are a more vulnerable 5%.

**Limited understanding of death.** Many of the participants (9 of 12) discussed children's inability to fully grasp the consequences – both emotional and physical – of suicidal behaviors and death. Questioning children's ability to verbalize suicidality with awareness and intent, P009 stated, "I don't know what their cognitive skills are to be able to say, 'I'm going to kill myself. I- I- this is what I want for me.' Uhm, 'I don't want to live. I don't want to exist.'” P010 questioned children's ability to connect self-harming behaviors with serious injury or death, and stated, "It's what they, you know, they consider to be soothing or whatever the case may be, not realizing that you're really hurting yourself. And you could really uh hurt yourself real bad.” Finally, P004 questioned children's ability to understand the permanency of death, and stated:

They're still in that kind of like concrete operational thought, uhm don't really have a lot of ability for abstraction yet. And so, that whole piece of like deductive reasoning and understanding what it means to die and not come back- is not really there.

Despite children's limited or absent understanding of suicide and death, the 22 treatment charts of suicidal children depicted suicidal thoughts and behaviors experienced by children from ages three through ten.

**Age of onset.** This study found that suicidality has affected children of all ages. P009 discussed how she has observed suicidality affect children as early as infancy. She stated:

You'll see infants when they suffer from or experience a traumatic loss of their primary caregiver, you find that these babies tend to uhm not really behave in a way that's going to help them survive so to speak. Like, they may not eat, they

may not yknow, engage with the world in general. They tend to be much more lethargic babies.

Children in the content analysis demonstrated symptomatology of suicidality as early as age three. (The study sample did not include children less than 3 years old because the branch of the mental health counseling agency from which the sample was taken did not serve children younger than 3 years.) The mental health histories compiled in the treatment charts, which explore health and wellness from conception to the present time, did not indicate suicidality prior to age 3 for any child included in the sample.

Onset in the preschool years (ages 3 or 4) occurred in 33.33% ( $n = 7$ ) of the treatment charts examined. Onset in the elementary school years (ages 5 through 10) occurred in 66.67% ( $n = 14$ ) of the sample. The mean age of onset was 5.76 years and the mode was 7 years (23.81%). The spectrum of suicidality, including ideation, verbalizations, behaviors, and attempts, affected children of all ages included in this study. For example, C018, a Caucasian female who was 3 years old at the onset of suicidality, experienced suicidal ideation, verbalizations, behaviors, and also made a suicidal attempt at age 3, which included trying to hang herself with a shoelace.

**Low intent to die.** The content analysis indicated that only 23.81% ( $n = 5$ ) of children reported a serious intent to end their lives, despite the fact that they all experienced suicidal thoughts, behaviors, or attempts. P002 described suicidality in young children as, “it’s more of an impulse rather than a desire.” Several of the treatment providers noted suicidal verbalizations with low intent to die. P005 stated, “The ones that I remember were kids that uhm would- was basically just screaming, yknow, ‘I wanna

die. I'm gonna kill myself.' ...But they never really- it was never really an- a plan or an intent." P004 stated:

When you would really ask a kid then, "What do you mean when you say you want to die?" and then they try to explain it, I mean it's really- "Oh, I didn't want to clean my room and I was trying to get my mom off my back," kind of thing. So, you hear that kind of stuff all the time. The true uhm intent to like harm oneself, I'd say that's yknow...pretty low.

Despite possible false alarms, P005 cautioned, "there are kids out there that are committing suicide." In addition, the treatment providers quite unanimously agreed that adults should take seriously any and all symptomatology of suicidality.

**Low frequency of suicide plans.** The content analysis found that only 9.52% ( $n = 2$ ) of children in this study created a suicide plan prior to making suicidal behaviors or attempts. This included both C001, who was 5 years old at the onset of suicidality, and C009, who was 7 years old at the onset of suicidality. The remaining 90.48% did not make any specific plans to self-harm. P004 commented that children may not be able to create detailed suicide plans:

So, so as a- where a teenager might be able to say, "I'm gonna get the gun that my dad has in the garage and I'm gonna shoot myself, and I'm gonna die and I'm never gonna come back," a 9 or 10 year old may say, "I'm gonna get my dad's gun and shoot myself," but not really understand where that's going to leave them or what that's going to mean for everybody around them. ...Uhm, and at the same time, might not be able to formulate that kind of plan with such...definity.

P011 described how childhood suicidality might arise suddenly because children are focused on the relief of negative symptoms or feelings instead of creating a plan to end their lives.

They're probably not going to be as well thought out in how they would do it.

Like I would just think that they would probably just be like, "I'm going to run in traffic." Or they'd just like- it almost feels like the energy (Shakes both fists rapidly in front of body in a short punching manner.) of kids that have it is like *bursting* with it, like, "I just need it to stop." ...It almost seems like with smaller kids, it's just like you know, they have a wound that they just need to like- or a pimple they just need to *pop!* because it's gonna burst! Like it's almost- it always feels like that to me when I'm dealing with it. So, uhm...I would say that's the difference. Like, younger kids it's definitely...it's definitely more of like an impulsive type thing of wanting something to stop.

**Consistent or ongoing suicidality.** The interview participants frequently discussed childhood suicidality as an issue that affected individual children for long periods of time – not simply fleeting thoughts of suicide. For example, P001 stated:

...There's one child in particular who I've worked with that uhm has a history of suicidality from ages 4 and the last trip that he took to [crisis unit] was in I think last May. And so there's been – he's 9 now – so I'd say that there's a good 5 years of yknow either ideation, plan, self-harm, uhm that sort of thing yknow consistently for about 5 years. He was hospitalized a number of times, uhm he was in a residential facility, he was in a partial hospitalization program, you know, sort of stepped down through the different levels of care.

P004 stated:

It's one of those things that if it comes up in a young kid, it's not gonna go away probably. The chances of them continuing to engage in that type of behavior is really high, and that increases the chances of death...

### **Causal Conditions of Childhood Suicidality**

This research found many reasons why children might have become suicidal, according to the detailed histories in children's treatment charts and through the stories told by the treatment providers. However, 6 axial codes represented the most frequent causal conditions of childhood suicidality, including: abuse & neglect, separation from a primary caregiver, other trauma & stressors, negative familial influences, mental illness, and physical illness. These causal conditions will be individually described below, with evidence presented for each axial code.

**Abuse & Neglect.** The following paragraphs will describe abuse and neglect, as reported in the treatment charts and in interviews with treatment providers, and as officially defined by the State of New Jersey. The Department of Children and Families (2014) described abuse as, "The physical, sexual, or emotional harm or risk of harm to a child under the age of 18 caused by a parent or other person who acts as a caregiver for the child," and neglect as, "When a parent or caregiver fails to provide proper supervision for a child or adequate food, clothing, shelter, education or medical care although financially able or assisted to do so."

**Abuse.** Abuse was explored in this study across three domains: physical, sexual, and emotional or verbal abuse. Statistics regarding all three domains were also collected. Abuse, in general, was reported in the treatment charts of 72.73% ( $n = 16$ ) of the suicidal

children in this study. It was also discussed in 11 of 12 interviews with treatment providers. Physical abuse was reported in the treatment charts of 50.00% ( $n = 11$ ) of suicidal children in this study; sexual abuse was reported in the treatment charts of 31.82% ( $n = 7$ ); and emotional or verbal abuse was reported in the treatment charts of 27.27% ( $n = 6$ ). There were several stories of abuse told by the participants and as evidenced in the treatment charts. P004 described the frequency of abuse in psychiatrically hospitalized children, and stated:

Real young kids, let's see...uhm...Have they suffered some kind of abuse? I mean, that it seems like, I mean to me every kid on the [child and adolescent hospital unit] has been abused in some way. You know what I mean? Like, you just kind of get that feeling over time. It's like, gosh, there's- these kids wouldn't be here if it weren't for something horrible happening in their life.

P002 also commented on the severity of abuse experienced by suicidal children, and stated that the abuse is:

Usually, to the extreme – like sexual abuse or severe physical abuse. Another example is a 9 year old boy was locked in a cage by his father uhm and just yknow beaten and things like that...So, it always seems to be very very at the extreme end of abuse uhm, in all of these children.

C015 was physically abused by his biological father, who utilized corporal punishment. The father hit the child with a belt, made the child kneel on the floor or stand on one leg for long periods of time, and once put the child's hands on the oven and burned him. P005 also described one particular child's story that included physical and emotional abuse. He stated:

The parents would put him in a uhm like a stor- plastic storage bin. (Gestures the size of a small box.) Would put them in and keep them in there for extended periods of time, to the point where they had to urinate. And...uhm...he...at Christmas they would break all their toys after they gave them to them and they would lock them out of the house.

C017 and C018, who were brother and sister, were both sexually abused for several months by their mother's live-in paramour's teenage son. C018 had experienced an onset of suicidality at age 3, many years prior to the abuse that occurred at age 7, but her younger brother, C017, had an onset of suicidality that seemed to immediately follow the disclosure of their sexual abuse.

P010 described his thoughts on emotional abuse as being significantly related to childhood suicidality. He stated:

Unfortunately, even parents are- are uh...factors that go into- because again, they kind of uh...beat their kids down mentally and physically, as well. I think a lot of it has to do with the mental- in my opinion, more mental than anything else. Again, you know, once you start breaking down inside the head, psychologically and everything else, that's a lot to do with it.

**Neglect.** Neglect was reported in the treatment charts of 36.36% ( $n = 8$ ) of the suicidal children in this study. It was also discussed in 2 of 12 interviews with treatment providers. Neglect was often found in the same children that had experienced abuse. In fact, only 1 participant in the study (C016) experienced neglect and no forms of abuse. This child, C016, had a history of neglect by his biological parents up to age 3, which was secondary to their drug use. In total, there were only 5 (or 22.73%) of the 22

children's treatment charts studied that did not include abuse or neglect. Some of the stories of neglect were quite severe. For example, P009 reported:

There was one little guy I remember...he had been locked in between two doors when he was three. When I say, "locked in between two doors," his body had been jammed in between these two doors. (Gestures with hands on mid-torso.) And the authorities believed it was for a couple of days while his mother was not conscious and within eyeshot of him. Now, this little guy probably- I would imagine that does a number on a three year old in terms of, "I need your help mom." Mommy's not responsive. He stayed there in between those doors until authorities removed him.

Another example of neglect was presented in the treatment chart of C003, a Caucasian female, who had a substantiated history of neglect from age 2 to 3. She had been exposed to drug use and paraphernalia by her mother, the home had no heat or hot water, and the child was found by neighbors to be naked and wandering the neighborhood alone. The child was removed from her mother's care, and subsequent visits resulted in the child coming home dirty and inappropriately dressed for the weather. Sexual abuse was also suspected due to the child's own sexualized behaviors.

In addition, neglect was found to have occurred not only within the biological home, but within the foster care system, as well. This was evidenced particularly by C014, who was left at home by a foster parent, prior to age 6 with a 2-year-old, a 1-year-old, and no adult supervision.

**Separation from primary caregiver.** Separation from a primary caregiver, by removal (for substantiations of abuse or neglect by the Division of Child Protection and

Permanency [DCP&P], formerly the Division of Youth and Family Services [DYFS]), divorce or separation, incarceration, or death, was reported in the treatment charts of 77.27% ( $n = 17$ ) of the suicidal children in this study. It was also discussed in 9 of 12 interviews with treatment providers. When asked about the most significant risk factors for childhood suicidality, P006 stated, “Separation. Multiple separations. Uhm. (Takes a breath; Pauses.) Multiple separations I think almost at the top of the list.” To illustrate the concept of multiple placements, C014, whose father was incarcerated, had been in 5 foster homes within a few months due to his “out of control” behaviors. He was 3.5 years old. C003, a 5-year-old male who presented with frequent suicidal verbalizations and behaviors, had been placed in at least 4 different foster homes prior to his 5<sup>th</sup> birthday, including 3 homes in a 6-month period. C013 also had a history of multiple placements; he was removed from his biological home at age 4 due to issues of abuse and neglect, he and his biological brother were moved to a foster home, and then the brother was adopted by the family, but C013 was removed from the foster home due to acting out behaviors.

The interviewer asked P005, who had worked extensively with children in specialized foster care, whether he felt children were more affected by the circumstances of abuse or neglect that led to their removal from home or the separation from their primary caregiver alone that was more traumatizing to children. He replied:

There were some of the younger kids that did say uhm, or that I would say they- their problem was more due to uhm...the circumstances that they were in. Not just being separated but just being angry around what happened to them. But I’d say the majority of it was uhm, being away from their parent.

P009 spoke about how young children's identities are often linked to their parents, and losing a parent may feel to them like losing themselves. She stated:

If they only know who they are in relation to their primary caregiver, and all the kids who I worked with were separated from their primary caregiver, that would suggest that those of them who were really suffering from that loss, were all at some sort of risk.

**Other Trauma & Stressors.** There were 3 focused codes that arose in the category of Other Trauma & Stressors, including: low socioeconomic status (SES), Trauma, in general, and Stress, in general. P009 discussed children's ability to manage traumatic experiences. She stated, "As resilient as kids are, they're not that resilient. They're not so resilient that they should have to put up with trauma after trauma after trauma because adults can't get it together."

***Low socioeconomic status (SES).*** Low SES was reported in the treatment charts of 95.45% ( $n = 21$ ) of the suicidal children in this study. This factor might have been so prevalent due to the payment options that the mental health agency accepted, which was primarily Medicaid, the federal health insurance program for low-income children and families. However, low SES was also discussed in 4 of 12 interviews with treatment providers. When asked about risk factors related to childhood suicidality, P006 stated:

Poverty. Definitely poverty. ...And you know when you walk in the home if there's poverty, there's a lack of resources, and to really call upon- a lack of supports in the family that they can really say, this is someone you can really trust and lean on.

P008 explained that low SES was also related to parents' poor education about normal childhood development, so that they might miss potential warning signs of suicidality.

She stated:

But our parents, uhm, their socioeconomic status really limits them. They don't have the good education on normal behavior for 5, 6, 7 year olds. Uhm, many of our children are treated like little adults. There's no boundary between adult conversations, child conversations, television programming...doesn't seem to matter who's watching, yknow? It's just being watched. So, the way children process some of those things and certainly like with fear with scary things on T.V., sometimes they have some interesting reactions, the poor kids!

P008 also reported that low SES affects treatment implications for suicidal children by limiting their access to services. She stated:

We would love to have more services based here in [town]. That is a major problem we face because for children to get any type of help, unless it's [name of agency] that comes out to the house, they have to drive to [another town], they have to drive yknow to different facilities, and so many of our families don't have a car. And so, then they're waiting for the bus to take them, and then...things get very hard.

***Trauma, in general.*** Trauma, in general, was discussed in 9 of 12 interviews with treatment providers. Regarding trauma and its many forms, P004 stated: "I don't know if it's the most significant [risk factor], but I think it's a really prevalent thing." P002 expressed similarly, "I don't think I've met a [suicidal] child that hasn't experienced some for of trauma." P003 noted that children who have existing mental

illness(es) might be more sensitive to traumas or have a compounded effect from traumas due to a lack of coping skills or other supports. She stated:

I think kids with mental health issues just experience trauma differently. Like, I feel like [name] presented like he experienced trauma but there was no... Like I feel like he just experienced stuff that a normal kid would experience, and experienced it as trauma.

***Stress, in general.*** General level of stress was not a category collected specifically on the chart data template. However, it was clear that all of the children included in the content analysis had experienced stress. In addition to the stressors already discussed in this chapter, such as abuse, neglect, and separation, there were also other stressors noted in the treatment charts. For example, 4 children (18.18%; C009, C017, C018, C019) reported feeling stressed by being verbally and/or physically bullied by peers. For C018, her bullying also included being choked and punched. Two (9.09%) children reported frequent self-blaming for their life circumstances; C010 blamed himself for intermittent contact with his biological parents (both of whom had heroin use disorders and his father had been incarcerated), and C011 blamed himself for his younger sister's physical illness (she had mitochondrial disease). In addition, 52.38% ( $n = 11$ ) of the suicidal children studied were students classified for special education, and 38.10% ( $n = 8$ ) had histories of school detentions and/or suspensions.

Still other stressors may be hidden. Four treatment providers (P001, P004, P006, P011) discussed grief and loss issues as potential triggers for childhood suicidality. P004 explained that an important investigative question to ask suicidal children is: "Have they recently experienced a loss, a death, a suicide in the family? Yknow, are they trying to

reconnect with a person they've lost?" P005 and P006 discussed emotional or psychological pain as a stressor. P005 explained, "They were in such pain that they wanted to hurt themselves." In addition, the stress of a suicidal child's behavior within a family system can be very taxing, as evidenced by the brother and sister relationship of C017 and C018. Their treatment charts referred to "frequent mental health crises," and noted that there were violent and aggressive behaviors amongst family members and destructiveness in the home. The mother of C017 described their relationship was a "work in progress."

Other hidden stressors may be related to holding multiple minority statuses, including the minorities of: race (54.55% non-white sample), mental illness (100% of sample), low socioeconomic status (95.45% of sample), special education (52.38% of sample), living outside of the nuclear or biological family (100% of sample did not live with both parents; 45.45% of sample lived with neither biological parent), and most importantly related to this study, the minority of age (100% of sample were children 10 and younger).

**Negative Familial Influences.** This section will describe 5 focused codes related to families negative influences on their children, including general dysfunction, family histories of mental illness, substance abuse, and suicidality, as well as parenting concerns. In general, these codes relate to the parents' negative influences on a child, but in several cases the negative influences of other close relatives, such as siblings, aunts and uncles, and grandparents, may have also affected the children's functioning, and as such, these persons' influences were included in data analysis.

***Family dysfunction.*** Family dysfunction incorporates many aspects of family life that may be outside of the typical range of healthy interactions. Family dysfunction was not specifically evaluated in the content analysis, due to the subjective nature of the construct and code, but it was generally discussed in 9 of 12 interviews with treatment providers. Domestic violence, which can be considered one aspect of family dysfunction, was measured in the children's treatment charts, and it was found that 42.86% ( $n = 9$ ) of suicidal children had family histories that included domestic violence. P004 explored other areas of family dysfunction, and she stated:

I think in the younger kids, a lot of time, it's more the family dynamic. If you're looking at it from like a social perspective. So, yknow, are the parents together? Are they divorced? Is there violence in the house? Uhm...what kind of relationship- like attachment- do they have with the parent and/or caregivers? Uhm...are they in like a hopeless kind of situation? Yknow, are they in foster care and they feel like they don't have anybody?

P008 discussed domestic violence and its effect on children. She stated:

I would think that uh, witnessing domestic violence is certainly a big risk factor for children because once they feel unsafe with the adults around them, time and time again I've noticed that children that have just those really severe escalating behaviors, it's because they see the adults that are supposed to be there caring for them, unable to care for them. And some children really cannot handle that.

P002 described another type of dysfunction within a family, which included multiple home placements and witnessing drug abuse. She stated, "She was passed around from family member to family member, uhm...witnessed her mom using drugs." P006

discussed that family dysfunction is a real barrier to treating children's suicidality because the family system may not be able to effectively support a suicidal child. She stated:

Yknow, dysfunction in the family. Uhm, definitely. Especially dysfunctional parents yknow, I mean like, that really can't modulate what they need. Uhm, those are the ones you really can't trust that they're going to see the signs, or they're- and they'll add to them! Yknow, they'll just feed into the problem.

Uhm, so that when you see a lot of dysfunction like that, you've got to be able to then uhm...judge at that point, can they stay in that home while this- these factors are going on. What do you have to put in place?

***Family history of mental illness.*** A family history of mental illness was reported in the treatment charts of 76.19% ( $n = 16$ ) of the suicidal children in this study. Specifically, 61.90% ( $n = 13$ ) of the suicidal children studied had a mother with mental illness; 47.62% ( $n = 10$ ) had a father with mental illness; and 61.90% ( $n = 13$ ) had another relative with mental illness. Familial mental illness presented in a wide range of psychiatric diagnoses, including: ADHD, anxiety, Autism, Bipolar Disorder, Borderline Personality Disorder, depression (including postpartum depression), Dissociative Identity Disorder, PTSD, Schizoaffective Disorder, and Schizophrenia. Related mental health symptomatology included histories of: anger management issues, physical assault, and sexual abuse. A family history of mental illness, most often parental mental illness, was also discussed in 5 of 12 interviews with treatment providers. P002 explained that parental mental illness may interfere with the parents' ability to help their suicidal children. She stated, "Or, yknow they obviously have their own – not obviously – but

some of them also have their own trauma to deal with and are not in an emotionally well place to be able to handle their own children's problems." P001 also noted that a non-biological guardian's mental health status might also affect children's suicidality. He stated:

But, the other child actually was, yknow – his caregiver, the guardian was actually somebody who was unrelated to him. It was like uh, his father's girlfriend, yknow in the past and she had yknow gotten guardianship. But she was responsive [to the child's treatment needs] but she herself was mentally ill and struggled with anxiety and depression. Uhm, she tried to be responsive but I think also had a difficult time helping him when she was also struggling a lot at home. And I think that was part of the reason why that that child in particular had a lot of difficulty.

***Family history of substance abuse.*** A family history of substance abuse was reported in the treatment charts of 85.71% ( $n = 18$ ) of the suicidal children in this study. Specifically, 57.14% ( $n = 12$ ) of the suicidal children studied had a mother with a history of substance abuse; 52.38% ( $n = 11$ ) had a father with a history of substance abuse; and 38.10% ( $n = 8$ ) had another relative with a history of substance abuse. Substances used by parents and other relatives of the suicidal children in this study included: alcohol, cocaine, crack cocaine, heroin (used intravenously), methamphetamine, opiates, as well as combinations of these drugs. A family history of substance abuse, most often parental substance abuse, was also discussed in 4 of 12 interviews with treatment providers. P001 described that parental substance abuse also led to incarcerations, which affected the

child. P002 also explained that children who witness their parents use drugs might add another level of stress to the child.

The content analysis showed that 100% ( $n = 21$ ) of suicidal children studied had families with histories of either substance abuse or mental illness, or both. Only 5 treatment charts (C005, C013, C014, C015, and C020) showed no family history of mental illness, and 3 treatment charts (C017, C018, and C021) showed no family history of substance abuse.

***Family history of suicidality.*** A family history of suicidality was reported in the treatment charts of 33.33% ( $n = 7$ ) of the suicidal children in this study. The suicidal person's relationship to the child varied, and included: a mother, two fathers, a maternal grandmother, a sister, a brother, and another unspecified relative. All of these individuals had histories of suicide attempts, and one chart specified suicidal behaviors. The method of suicide attempt was generally not reported. However, C019's treatment chart reported that the child's biological father engaged in the following suicide attempts: "slit wrists in front of [child's] younger brother, tried to hang himself a few times, and uses drugs." Two of the children in the study (C009 and C015) had reportedly witnessed others' suicidality, whereas 3 of the children (C017, C018, and C019) were simply aware that others had experienced suicidality.

A family history of suicidality was also discussed in 6 of 12 interviews with treatment providers. P001 described a family history of suicidality in two of the suicidal children that he served. In one case in particular, the family history included a suicide attempt by his mother, his paternal grandmother, and his current non-biological guardian. P001 stated:

The one boy, uh [child's initials]. He was – there was somebody that he knew that attempted. His mom had actually attempted. When she was a teenager. ...And his father also uh – I think he, did he? (corrects himself) no he didn't try to commit suicide. I think his biological – his paternal grandmother attempted suicide at one point. And actually, his guardian did when she was younger as well. ...Yeah, because she had sexual trauma when she was a child. And she disclosed to me that she had attempted when she was like 18 or 19. And she was hospitalized.

According to P001, the child was not a witness to these suicide attempts, but he was aware of them.

P007 and P008 both verbalized feeling cautious about any discussion of suicidality (including prevention) in a school setting because of children's potential family history of suicidality. P007 stated:

I guess the other part of it too is uhm- you know in the past, we've had students who've had family members who've committed suicide. So then, almost trying to be sensitive to where kids are with the suicide of another. And how we talk about su- and I guess in some ways, my thinking along that is...(Pauses.) I'm trying to think how to put this in the best way. We try to be sensitive to- if there's a particular family where a family member had committed suicide, and then we're sharing a story about being careful about bullying because it could result in suicide. Or, maybe if there's this one thing that you did that could have changed everything. And that could be true! That- yknow, there are people who have written about how, "I was going to go home and I was going to do this were it not

for this person saying this incredibly uplifting thing to me, that I might not be here today.” But we have to careful of that with this level of kids, uhm who’ve had a family member who may have taken their lives. Because the guilt that comes along- it’s hard enough to process all of that as an adult. Uhm, let alone if you have an older sibling who has successfully completed a suicide. And you’re in kindergarten.

P008 stated:

Well, and then I’m never sure if there is someone else in the house who has been suicidal or what they’ve- I can’t know what their life experience has been. So, you want to err on the side of caution.

***Parenting concerns or involvement with the Division of Protection & Permanency (DCP&P).*** A history of parenting concerns or involvement with DCP&P (formerly, the Division of Youth and Family services [DYFS]), was reported in the treatment charts of 81.82% ( $n = 18$ ) of the suicidal children in this study. Involvement with DCP&P generally indicates that parents have been referred or reported for suspected abuse or neglect related to their child’s welfare. It does not necessarily mean that the abuse or neglect has been substantiated or that children have been removed from the home. Parenting concerns were also discussed in 4 of 12 interviews with treatment providers. P005 discussed how one parent contributed to her children’s poor mental health. He stated:

They were in- those were the kids in foster care. Uhm...yeah, they were out-of-home and either they were severely abused, or their mother was making- it was always- it was always predominantly- it was predominantly their mother that was

the source of their pain; their discomfort. They were separated from mom. And then their mom made false promises that she was going to come back and yknow get them or whatever, she was getting better, but that would uhm...usually be the trigger.

Regarding treatment for suicidal children, P002 noted that parenting concerns (as well as the children's concerns) should be addressed. She stated:

Yknow, kids don't just come out suicidal, obviously there's something going on yknow, at home that needs to be addressed. And so, I don't think you can just work on the kid, you need to work on the whole family.

The content analysis also showed that 33.33% ( $n = 7$ ) of the suicidal children in this study also experienced a strained relationship with one or more of their parents.

**Related mental health diagnoses.** Psychiatric diagnoses aligning with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (*DSM-IV-TR*), were reported for 21 out of 22 suicidal children included in the content analysis, and one chart had incomplete information. All children admitted to the counseling agency from which the treatment charts in the content analysis were derived were required to have a primary mental health diagnosis. Therefore, all children had at least one diagnosis, and all but two had multiple diagnoses. The mean number of diagnoses was 4, with a range of 1 to 9 psychiatric diagnoses. Past diagnoses were included in this count, but Rule-Out diagnoses were excluded from the study, as this designation indicates the child did not meet criteria for a full diagnosis. The most common diagnoses and conditions (hallucinations and psychosis are symptoms, not disorders) are listed in the table below.

Table 5.

*Most Frequent Psychiatric Diagnoses and Conditions*

Diagnosis	<i>n</i>	Percent of sample	Interview Agreement
Attention Deficit Hyperactivity Disorder	16	76.19%	2
ANY Mood Disorder	12	57.14%	8
<i>Mood Disorder NOS</i>	9	42.86%	2
<i>Major Depressive Disorder</i>	3	14.29%	1
<i>Bipolar Disorder</i>	2	9.52%	3
<i>DMDD*</i>	1	4.76%	0
<i>Depression, in general</i>	0	0.00%	4
Adjustment Disorder	8	38.10%	1
Posttraumatic Stress Disorder	7	33.33%	5
Oppositional Defiant Disorder	6	28.57%	2
Hallucinations or Psychosis	5	23.81%	5

*Note.* *n* = Number of treatment charts that included the code. \*Disruptive Mood Dysregulation Disorder (DMDD) was introduced as a new, unique disorder at the release of the DSM-5, in May 2013.

Speaking generally regarding mental health diagnoses and suicidality, P004, a child psychiatrist stated:

I think it's something like 90% of kids with suicidal ideation have some site-some type of psychopathology. So we have to figure out what it is. Uhm, it's

usually depression but it could be yknow uhm, history of abuse, whether or not they've got PTSD symptoms or not, uhm anxiety, disruptive behavior disorders, I mean, really trying to figure out what's going on.

Similarly, P007 described the suicidal children that she has encountered:

I would say at least half of them, if not more, had some kind of diagnosis, whether it was a medical diagnosis or a mental health diagnosis. ...Uhm...epilepsy, or childhood bipolar, or something along those lines. ...Uhm...(Pauses.) I'm thinking now it might have been in almost every case.

***Attention Deficit Hyperactivity Disorder (ADHD).*** ADHD was reported in the treatment charts of 76.19% ( $n = 16$ ) of the suicidal children in this study. It was also discussed in 2 of 12 interviews with treatment providers. Hyperactivity, as a characteristic potentially related to suicidality, was only listed in 3 treatment charts (C002, C005, C022) from the content analysis. However, the majority of children in this study (80.95%,  $n = 17$ ), including all of the children diagnosed with ADHD, were also prescribed medication to control the symptoms of ADHD. Therefore, ADHD symptomatology, such as hyperactivity, may have been masked or eliminated with the psychiatric intervention.

***Mood Disorders.*** In the *DSM-IV-TR*, mood disorders were grouped together in the same section, and included depressive disorders and Bipolar disorders. Due to the age of the treatment charts and date of diagnosis for the children studied, the researcher similarly grouped mood disorders for this manuscript. Table 5 generalizes the mood disorders into the category "ANY Mood Disorder" and then breaks down the specific diagnoses and topics as subgroups. Mood disorders were reported in the treatment charts

of 42.86% ( $n = 12$ ) of the suicidal children in this study. Mood disorders were also discussed in 8 of 12 interviews with treatment providers.

Depression, in general, and Major Depressive Disorder were reported in 14.29% ( $n = 3$ ) of the treatment charts and discussed in 5 of 12 interviews with treatment providers. Bipolar Disorder was reported in 9.52% ( $n = 2$ ) of the treatment charts and discussed in 3 of 12 interviews with treatment providers. Disruptive Mood Dysregulation Disorder (DMDD) was reported in 4.76% of treatment charts ( $n = 1$ ) of the suicidal children in this study. Mood dysregulation in general (not the formal diagnosis), was discussed in the interviews with 1 of 12 treatment providers. P001 described how mood dysregulation affected one of his clients:

The incidents while I was working with him yknow just a lot of problems with mood regulation and stuff like that and that would seem to be a significant yknow trigger for him. Any sort of incident that would cause him to become upset – or he would be yknow be challenged by authority or something, yknow kind of triggered that feeling of, I guess, frustration and he didn't really – kind of spiraled and yknow usually ended in him resulted in being destructive or slamming his head, and banging his head, and at one point he tried to bust out a window and jump out of the window – wanted to jump out of the window. Another time he wanted to run into traffic.

***Adjustment Disorder.*** Adjustment Disorder was reported in the treatment charts of 38.10% ( $n = 8$ ) of the suicidal children in this study. It was also discussed in 1 of 12 interviews with treatment providers. P003 stated: “The big diagnosis here is adjustment disorder.” She went on to explain that in her mental health preschool setting, it was

difficult to obtain accurate diagnoses of more significant mental health issues in 3-to-5-year-old children.

***Posttraumatic Stress Disorder (PTSD).*** PTSD was reported in the treatment charts of 33.33% ( $n = 7$ ) of the suicidal children in this study. It was also discussed in 5 of 12 interviews with treatment providers. Traumas, in general, were discussed by 11 of 12 interview participants. Although trauma itself seems to be a significant risk factor for childhood suicidality, not all children who experience trauma meet the criteria for a diagnosis of PTSD. P002 remarked about suicidal children: "...It's really hard to understand that everybody deals with their own trauma in their own way." At the same time, P003 commented about the preschool-aged population she served, "I feel like PTSD is underdiagnosed in my kids."

***Oppositional Defiant Disorder (ODD).*** ODD was reported in the treatment charts of 28.57% ( $n = 6$ ) of the suicidal children in this study. It was also discussed in 2 of 12 interviews with treatment providers. Oppositional defiance was also described previously in this chapter under the "observable qualities of suicidal children" section and in Table 3.

***Hallucinations or Psychosis.*** Hallucinations (both auditory and visual), or psychosis, was reported in the treatment charts of 23.81% ( $n = 5$ ) of the suicidal children in this study. It was also discussed in 5 of 12 interviews with treatment providers. P001 and P012 both described children that they had worked with who had experienced auditory and visual hallucinations of a spiritual nature. P001 described a male client's hallucinations, as: "they were always around uhm like God and the devil like talk-

speaking to him.” P012 described a 9-year-old female client who had cut herself repeatedly with thumbtacks and also had auditory and visual hallucinations. P012 stated:

She would tell me that uhm she’d see the devil, right? ...She says that she sees things and she can hear things. ...Well, the more that I worked with her...uhm, the mom was telling me and the kid was telling me that it’s the devil. ...She said that it would tell her to kill herself. It would tell her to cut. It would tell her to do all these things.

P004, a child psychiatrist, discussed how she felt it was unclear if auditory hallucinations stemmed from true psychosis or were the reaction to traumatic life events. She stated:

Somebody had threatened to kill them in some way, and now they’re reporting, “I’m hearing voices and it’s telling me to kill myself by doing X.” Uhm, I think I’ve heard that a lot more in like the young, young kids. *Interviewer: Do you think it’s really a psychosis or...?* P004: I think it’s really hard to tell. But honestly, in my experience, a lot of the kids that have reported auditory hallucinations have been kids who’ve been through something horrible. And so, is it a hallucination so much as kind of replaying in their head something that they’ve heard before?

**Related physical health diagnoses.** All of the children involved in the content analysis (for whom there were complete data) had been diagnosed with at least one physical health ailment in their histories. These ranged significantly, and some examples were: broken bones, high cholesterol, concussions or head trauma, developmental delays, eczema, heart murmur, lactose intolerance, lead exposure, obesity, scabies, seizures, thyroid problems, etc. The most common medical issues are displayed below in Table 6.

Table 6.

*Most Frequent Physical Health Diagnoses and Conditions*

Diagnosis	<i>n</i>	Percent of sample
Poor sleep or Insomnia	12	57.14%
Asthma	10	47.62%
Enuresis	10	47.62%
Frequent ear infections or Ear tubes	8	38.10%
Seasonal or Environmental allergies	7	33.33%

*Note.* *n* = Number of treatment charts that included the code.

Physical health conditions were only discussed in 2 of 12 interviews with treatment providers. Specifically, P007, a school counselor, mentioned that one suicidal child with whom she had worked previously had been diagnosed with epilepsy. She also noted that suicidal children may be prone to making somatic complaints. She called these children “frequent flyers in the nurse’s office,” and stated, “Because sometimes kids who won’t really talk to me, man, they will spill to [name] – she’s our nurse. ...And if they’re down there with constant somatic issues or aches and pains, or ‘my finger hurts,’ or, yknow...uhm, yeah.” P006 was a significant advocate for bridging the connection between children’s mental health and children’s physical health. Prior to becoming a therapist, P006 worked as a pediatric nurse. She emphasized the importance of physical health as it relates to childhood suicidality. She stated:

And you also have to look at the physiological things that are going on. And whether there's any physiological factors that might be factoring in. And as a nurse, I have to look at that. Yknow, like, what else is going on?

P006 went on to describe many physiological conditions that may be related to suicidality in children 10 years old and younger, including: autoimmune disease (such as Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections [PANDAS] and Pediatric Acute-Onset Neuropsychiatric Syndrome [PANS]), lupus, cerebritis, encephalitis, kidney disease, glomerular disease, rheumatic fever, thyroid dysfunction, diabetes (uncontrolled), and Lyme disease. P006 went on to describe how certain medical diagnoses may place children at increased risk for suicide. She stated:

Oh God, I could go down the list- there's a lot of different things. Kids with thyroid dysfunction, any time you get that, they could kill themselves. Because they are physiologically not functioning normally. And when you're not funct- at any time, and it might not even be purposeful! – but uhm, they purposefully do things, but they're not in their right mind, either. But then, neither is a suicidal patient. So where do you draw the line? ....Uhm, so even if they're not trying to kill themselves, they could kill themselves if they like do something- yknow, like that's not safe during those times. Uhm, so where do you draw the line? I think it's a hard- I think when- and then how many of the kids that are making bad choices, whether you call it suicide or not, have a physiological component? We just don't even know!

Drug use and exposure was also explored in the content analysis. Only one child (C022) reported voluntary alcohol consumption on one occasion. The report stated,

“Child reported he drank champagne once until he vomited.” There was no other drug or alcohol use reported in their treatment charts by any of the children. However, it was reported that 19.05% ( $n = 4$ ) of the children had been exposed to drugs in utero, and 14.29% ( $n = 3$ ) of the children were born drug addicted. Therefore, 76.19% ( $n = 16$ ) had never had any drug or alcohol use.

**Complex interaction of triggers.** As with the previous focused code of stress, in general, a “complex interaction of triggers” was not a category collected specifically on the chart data template. However, it was evident through the content analysis that all of the children had experienced many different potential triggers for suicidality. Five treatment providers (P001, P007, P009, P011, P012) discussed how childhood suicidality is a complex condition that stems from multiple factors. P007 stated, “There are kids who kind of came to us with many, many challenges, that could certainly make their whole school experience very difficult...in a lot of ways. So...it’s a multilayered thing for them.” To give a specific example, P001 described one male child he had worked with who had multiple triggers that seemed to affect his suicidality. He stated:

Yeah. Well, there - it seems like there’s just kinda ongoing consistent stress, like whether it’s economic uhm yknow... He’s estranged from his biological father but he’s not aware that he’s estranged. He has this relationship with this other man who I think he questions whether or not this guy is actually his biological father and he’s not. Uhm, mom has a terminal illness. Uhm...and... again, financial hardship. His grandmother passed away uh...about a year and a half ago. Uhm...And then the other thing was when mom, when I was initially doing a biopsychosocial assessment, was - there was an incident when he was like 3.

And mom didn't really feel like it was a huge deal, but in describing it you could see that it was actually more of a - had more of an impact on him and her, but there was a *fire* where they lived. ...So, and it was....they got out of the house and everything like that. But this was kind of like right before everything started to happen. So, maybe that wasn't like the singular event that triggered everything, but I think it played a major factor – at least in my opinion – in as into what happened to him.

### **Treatment Implications for Childhood Suicidality**

This research found many treatment interventions that have been used to treat suicidal children, according to the detailed histories in children's treatment charts and through the stories told by the treatment providers. However, 1 axial code represented the most frequently used psychiatric interventions, including the 3 focused codes of crisis screening, psychiatric hospitalization, and psychotropic medication. The relationship to the core category of childhood suicidality can be viewed in Figure 1. In addition, the researcher will introduce in this section The RESCUE Model for Childhood Suicidality, which can be used as a guide for treatment providers encountering suicidal children 10 and younger. These treatment implications will be individually described below, with evidence presented for each focused, axial, and theoretical code.

**Psychiatric interventions.** Psychiatric services and medications were referred to in the majority of interviews with treatment providers and in all of the treatment charts of suicidal children. As such, it seemed that awareness of these services in the New Jersey community was high, and might also imply that stigma about using psychiatric services was lesser than stigma regarding other counseling or school-based interventions. Three

focused codes were found among the psychiatric interventions, including: crisis screening, psychiatric hospitalization, and psychotropic medication. Each of those codes will be described below, with evidence provided from the interview and treatment chart data.

***Crisis screening.*** A history of crisis screening was reported in the treatment charts of 31.82% ( $n = 7$ ) of the suicidal children in this study. It was also discussed in all 12 of the interviews with treatment providers. The term “crisis screening” to this treatment provider sample generally implied that a child would have to visit a crisis center in a hospital setting to meet with a specially trained clinician to evaluate the child’s suicidality and need for psychiatric hospitalization. (During an active crisis, a mobile response team might alternatively be deployed to the child’s school or family home to evaluate the nature of their suicidality.) All of the treatment providers agreed that appropriate screening for childhood suicidality was a critical first step in the treatment of suicidal children. It should be noted that crisis screening was also included in the agency’s and schools’ protocols for how to manage a suicidal child. For instance, P008 reported about her school: “Our school policy is that they either need to be cleared by a...yknow, either a psychologist or some sort of therapist, or your family doctor.” However, many of the treatment providers criticized the current system of screening by the county’s primary hospital-based crisis center.

P001 described his frustrations about how crisis screeners apparently had different clinical opinions about a child’s suicidality than P001 did when he recommended the screening. He stated: “I’ve had experiences where the child will go to [crisis center] and they don’t feel that he or she needs to be hospitalized and I may disagree.” P004, a child

psychiatrist who herself had several years of experience working in a hospital-based setting, echoed this sentiment: “We feel like we send kids over and a lot of times they end up discharged.” One reason for the discrepancy may be the level of service that the child receives at the crisis center. The crisis screeners are not psychiatrists or even counselors, but Bachelors-level employees trained in crisis intervention. P004 confirmed, “All the kids don’t need to be seen by a psychiatrist. ...Technically they don’t even need to be eyeballed by us.” P004 also voiced concern about the level of training of the psychiatrists who work at crisis centers. She stated:

A lot of the docs in crisis centers are not child docs. There’s just not that many of us. So, they’re treating- when- even if when a doc was to see a kid, uhm...they’re treating them like a little adult. And kids are not little adults. Kids are kids.

Several of the participants also described a long wait time at the hospital to get children screened, which itself may decrease a child’s expression of suicidality. P005 explained:

The big thing was getting them to [hospital-based crisis center] and then staying with them and trying to keep them occupied, which often meant entertaining them. ...And when a kid is entertained for an- for hours, I think at that point they’re- they become okay. ...And then the clinician or whoever sees them and they look at you like, “Why are you doing this?” (Shakes head no.) Yknow, “Are you stupid?” And there’s no...Yeah, I really often felt like crisis was not very understanding. (Shrugs; gestures with palms face up.) It wasn’t taken seriously.

P002 discussed that a child’s visit to the crisis center may in and of itself be traumatizing because the centers typically serve all age groups and do not have services specifically geared for children. She stated:

And they're going to send the kid to [crisis center] and that's not necessarily always the best – best thing for the child. Because yknow, I've sat in at [crisis center] with kids before and you've got adults pulling out their hair, thinking tarantulas are crawling all over them. ... You can be sitting there 36 hours before you even see a doctor. Just to be told that you can go home.

Despite their many concerns with the screening center and its staff, the treatment providers generally felt that having a crisis screening was essential. P012, a clinical mental health counselor, explained that she felt unprepared to evaluate children's suicidality, and recommended the crisis center. She stated:

You can take them to crisis. You know, like let crisis do their stuff. See what they say. Because sometimes I feel like, for somebody like me who is not really like knowledgeable on the subject, like it's not my specialization, I feel like let somebody who knows a lot about it decide what the next step it- to do- is. You know? Because who am I to say like, "Oh yeah, she's good to go," when I'm not really sure if she's good to go.

Similarly, P011, a clinical supervisor, reported that the most important intervention for suicidal children is crisis screening. She stated:

Screening. Definitely qualified screeners. People that are specifically trained to be able to do that. That's the most important. *Interviewer: Do you think – and because you're a supervisor – do you think clinicians, our clinicians, are trained to really evaluate for suicidality?* No. No. That's why all the time I'm always like, "Send 'em, send 'em, send 'em." You know. ... Send them! I don't care! Send them! Send them! That's- I'm always- yeah, I don't try to pretend that I'm

anything other than what I am. I mean, all I know is what my- my role is not to evaluate whether or not there's...if they're suicidal or not. If I just know of it, and they've mentioned it, then I'm sending them...to somebody that is qualified.

***Psychiatric hospitalization.*** A history of psychiatric hospitalization was reported in the treatment charts of 59.09% ( $n = 13$ ) of the suicidal children in this study. Of the 13 children who had been hospitalized, six children (27.27%) had been hospitalized once, six children (27.27%) had been hospitalized twice, and one child (4.55%) had been hospitalized seven times by the time he was 6 years old. In all cases, the hospitalizations were related to suicidality. P002 explained the need for hospitalization of suicidal children. She stated, "If the child really isn't that safe and they really...they need somebody watching them all the time and figuring out what the best medication is for them." P004 described the goal of psychiatric hospitalization, from the hospital's point of view. She stated, "This is gonna sound really jaded, but...uhm, figure out what the underlying issue is, and try to fix it in the fastest way possible."

Psychiatric hospitalization was also discussed in 10 of 12 interviews with treatment providers. As with the crisis screening theme, psychiatric hospitalization also had mixed reviews from the treatment providers. P004 described two very favorable outcomes of psychiatric hospitalization to be increased family communication, and connection to additional mental health and psychiatric services. She stated:

I think probably the biggest thing that happens when a kid is on a unit is that they require a family meeting. And it forces the parent or guardian to come in and sit down with the child in the room with a professional, talking about things that are going on. And I think that communication often isn't happening at home and I

think that's a big step for families. *Interviewer: Yeah. Mhmm. And they might not have had counseling services in place prior to this emergency happening.*

P004: Right! Right. So, and that's the other thing. I mean, every kid that leaves the hospital is gonna have some kind of follow-up plan, be it a partial program, or an IOP, or being hooked up with a therapist and a psychiatrist, or something like that. So, they are gonna have more services available to them at that point.

One of the most important concerns that the treatment providers voiced regarding psychiatric hospitalization for suicidal children was that treatments were not always age-appropriate. P003 described the experience of a 5-year-old male child that she referred to the hospital. She stated, "There aren't really other 5 year olds there," and regarding the psychoeducational groups, "I don't necessarily think they're age-appropriate for him." Another concern regarding psychiatric hospitalization was the general lack of hospital beds for children with psychiatric needs. The bed shortage makes it so that suicidal children may have to be placed in hospitals that are far away from their home. P001 explained:

I think that a lot of the difficulty is – yknow, especially when the parents take the kids is just because they're being screened there and they live in [name of New Jersey county], does not necessarily mean if they need to be hospitalized that they'll be in [the same New Jersey county]. So my experience has been kids can be referred out to hospitals in Pennsylvania. I had a kid go all the way down to [name of New Jersey town] to [name of hospital]. And it makes it extremely difficult then for the parents to be supportive when they have to travel like 70 miles to get to wherever the child is.

***Psychotropic medication.*** Psychotropic medication was reported in the treatment charts to have been prescribed to 80.95% ( $n = 17$ ) of the suicidal children in this study. It was also discussed in 7 of 12 interviews with treatment providers. A total of 27 different medications were prescribed, with the most frequent being Adderall or Adderall XR (47.62%,  $n = 10$ ), Risperdal or risperidone (47.62%,  $n = 10$ ), and Tenex, Intuniv, or guanfacine (38.10%,  $n = 8$ ). When broken into classifications of drugs, it was found that this sample was most commonly prescribed medications used to treat symptomatology of ADHD or anxiety (80.95%,  $n = 17$ ), and medications used to treat mood lability (66.67%,  $n = 14$ ). Medications used to treat depression were much less commonly prescribed (antidepressants were prescribed to 19.05%,  $n = 4$ , while selective serotonin reuptake inhibitors (SSRIs) were prescribed to 14.29%,  $n = 3$ ). In summary, only 7 (or 33.33%) of the 21 suicidal children with known psychiatric histories had been prescribed medications used to treat depression. During member checking with P004, a child psychiatrist, P004 commented on feeling surprised at the lower frequency of prescribed medications used to control mood, and the higher frequency of prescribed medications used to control hyperactivity and inattention.

Interviews with the treatment providers yielded mixed feelings about prescription medications for suicidal children. For example, P001 stated, “Sometimes medication is definitely helpful because some of these kids I think are like a hot car engine, and you need to really like cool things down in order to really address some stuff.” Later in the interview, P001 cautioned, however: “Any drug in a child is a drug in a child. I guess it’s my philosophy that you want to see what you can do without meds before you start pumping them in.” Similarly, P006 stated: “You heal them, you don’t just medicate

them. Uhm, but medication is necessary, I'm not saying it's not." Echoing this sentiment, P011 stated:

I've seen some positive things with medication, although I'm not a huge proponent of medication in children, but I have seen some in teenagers, uhm...you know, take the edge off and help them. Uhm, but...I don't see long-term positive effects from it. I think therapy is more effective.

While P003 also had mixed feelings about medicating suicidal children, she also found that for one 5-year-old suicidal male in particular, that medication – specifically Adderall – was the only treatment that seemed to be predictably effective. She stated: "Everything else has pretty much backfired." On the Adderall, she explained, "he's able to think about things before he does them a lot more," and the reduced impulsivity in turn reduced the child's suicidal behaviors, as well.

### **Specific interventions, Introducing The RESCUE Model for Childhood**

**Suicidality.** As reported in the treatment charts and in interviews with treatment providers, there were over 50 unique treatment interventions, spread across 28 treatment modalities, to address childhood suicidality. Interventions ranged significantly, from creating safety plans, and collaborating with family members, to very specific behaviors to decrease anxiety and calm the child (e.g., fanning them, allowing them to get a drink of water or a tissue, giving hugs, pushing against a wall), to specific therapeutic interventions (e.g., Cognitive Behavioral Therapy, increasing the child's emotional vocabulary, role play with puppets), and involving the child in activities to boost socialization and self-esteem (e.g., Scouts, karate, music lessons). Despite the large range, interventions listed in the treatment charts had low frequency, and typically

applied to only 1 or 2 children. This is most likely due to the large range of issues that triggered the children's suicidality. Specific issues and specific problematic behaviors required equally specific interventions, and so the interventions were uniquely tailored to individual children.

The researchers found, however, that the interventions could be grouped in order of 6 steps that could generally apply to treatment providers encountering suicidal children. These steps were organized by the research team into the acronym, R.E.S.C.U.E., which stands for Respond to the situation; Evaluate the nature and severity of the child's suicidality and other problems; ensure Safety across settings; Collaborate with the child's treatment team and a clinical supervisor or consultant; Understand the child's emotions and try to calm them; and Engage in specific interventions to reduce symptomatology of suicidality and other biopsychosocial issues. For quick reference, the meaning of the acronym can be remembered by the words: Respond, Evaluate, Safety, Collaborate, Understand, and Engage. The following paragraphs will describe the steps of The RESCUE Model for Childhood Suicidality in greater detail and will provide evidence for their relevance to treatment for childhood suicidality from the interviews with treatment providers.

***Respond (R).*** The "Respond" theme is the first step of The RESCUE Model for Childhood Suicidality and it describes how an adult can best respond to a child 10 or younger who demonstrates suicidality. First, the adult should take all warning signs, verbalizations, threats, or behaviors of childhood suicidality seriously (P002, P004, P005, P007, P008, P009, P010, P011). Adults should recall that for young children, warning signs may present in artwork, play, or in less overt behaviors, such as poor self-care (food

refusal, lack of hygiene), or moodiness, and that suicidal verbalizations are not required, as children do not always have the verbal skills or emotional vocabulary to express suicidality with words. As P005 stated, “Take it seriously...err on being conservative.” Adults need to have an awareness of the characteristics of childhood suicidality and should take the initiative to respond to all potential warning signs. P009 added, “Don’t assume” that a child can’t be suicidal or that the situation will resolve itself. Also, adults should never ignore a child’s suicidality (P010, P011).

In addition, several treatment providers (P001, P008, P010) highlighted the importance of remaining calm. It is very important for the adult to respond with compassion and empathy to the suicidal child (as suggested by P001, P003, P004, P009, P010, and P011) because it is likely that they are experiencing deep emotional pain. P001 explained: “I think you need to be compassionate and empathic and yknow, in your responses to kids, I think you’ll help them to deescalate a little bit better.” While it might be natural for adults to feel frustrated by a child’s tantrum or acting out behaviors, reacting empathically to suicidal children is more appropriate. Considering that the triggers of childhood suicidality are generally traumatic (abuse, neglect, separation from a primary caregiver, etc.), it is possible that reacting with anger would re-traumatize suicidal children, and may create a barrier between the child and the adult. The last step of the Respond theme is to begin to act immediately to help a suicidal child. As P004 explained:

If you have a real concern about a kid, it needs to be addressed immediately.

Because the fact is, if something happened a week ago, and the kid is just getting

to the ER 5 days later, they're not going to be taken seriously. It needs to happen then!

As ongoing stigma about childhood suicidality was found to be a barrier to effective treatment, some treatment providers will need visual or verbal "evidence" of childhood suicidality to take a suicidal child seriously. This "seeing is believing" quality about childhood suicidality makes it different from other crises. For example, if a child presented at an emergency room following a house fire, the doctors would not doubt the house fire, but would treat the child immediately for burns, smoke inhalation, shock, and other possible risks. With childhood suicidality, helping professionals continue to doubt its existence and may send a child away without treatment, as P004 described above. This may also differ from adolescent or adult suicidality, as treatment providers would likely take adolescents and adults more seriously for many reasons, including a perceived greater accuracy of self-reporting, and would offer appropriate treatment.

***Evaluate (E).*** The "Evaluate" theme is the second step of The RESCUE Model for Childhood Suicidality and describes ways in which the adult responder can gather additional information about the suicidal child to weigh the seriousness of the situation and later know which resources to utilize. Some evaluation is done rather informally. As P010 suggested, adults should be observant about any changes that might occur in a child's typical behavior. He explained:

As parents and even as case managers, you pretty much have to know your kids. It's just if they come acting totally different- especially- especially if it's something that- you know, as I said, again, kids come to us. ...Unfortunately with parents and everybody else, you know, if you're not really paying attention

to your kids- if you really don't know your kids and their behaviors change...yknow, ask questions. Uh...I think that's just the biggest- the biggest factor right there is that you have to kind of understand if your kid is acting totally, totally different. Why are they acting different?

As P010 explained, after an adult observes a behavior change in a child, the next step is to ask probing questions to understand their situation and learn more about their suicidality (P001, P003, P004, P007, P010, P011, P012). Asking questions also requires that the adult be patient and listen to the child's full answers (P007, P010, P012).

Children might have different words for expressing suicidality, and it is necessary to use terminology that they can understand – instead of “suicide,” the adult could say “hurting yourself,” for example. Similarly, adults might have to interpret children's words and descriptions of their emotions carefully. P007 stated: “Really listen to what they say, and if you're not sure what they really mean, then ask them what they really mean!”

The most important part of the evaluation step is to assess potential risks for the child and those around them (P006, P007, P008). Risks can include both physical and emotional consequences. For example, if a child reported that they planned to burn their house down, it would be important to evaluate the child's level of intent, their ability to access means to set a fire, their supervision needs, their emotional health needs, and the needs of others who might be affected by a real fire or simply by the child's suicidality. Three participants (P006, P011, and P012) also reported a need to evaluate the child's overall wellness to determine why they might be feeling suicidal. As P006 recommended, “Look at the total child and their health and their wellbeing, to look at whether that- whatever diseases they may have, or medical imbalances they may have,

factor in to their thought process and all that.” Later in the interview P006 added, “It’s really treating them as whole people. You know, you’ve got to really- they’re little, little people that are whole people. You can’t break them up and chop them up.”

***Safety (S).*** The “Safety” theme is the third step of The RESCUE Model for Childhood Suicidality and it describes ways to ensure safety across settings. All of the treatment providers interviewed discussed safety as an essential goal of working with suicidal children. P006 stated:

You really have to put in safeguards and- uhm and safe- not just in terms of like (Uses a deeper voice.) “Well, are you thinking of killing yourself?” You just gotta make sure that there’s as much safety surrounding them as you can. Because they have more ability to do something...awful. You know that could really kill them.

There were many ways that the treatment providers suggested that adults could ensure the safety of suicidal children. One of the most frequent suggestions was to increase children’s level of supervision by a trusted adult (P002, P006, P007, P008, P010, P011, P012). P006 stated:

I think number one you gotta keep them safe. So number one you’ve got to really make sure that the environment is safe. There still has to be vigilance yknow, if they- if they are at risk. There has to be vigilance in supervision. I don’t know how else you get around it.

Unlike adolescents or adults, children might not be able to evaluate the level of supervision or support that they need, so increasing supervision while the child is awake – and even at night – is the adult’s responsibility.

A second commonly suggested method of ensuring safety is to limit suicidal children's access to lethal means (P003, P004, P005). P004 stated:

Uhm, I mean, to me limiting lethal means is a huge thing. Uhm, so, yknow I think firearms used to be the most uhm- most used means. I think they've kind of taken a backseat to suffocation type stuff like hanging and things like that. But, I mean, yknow, you've got a kid who says something about killing themselves and you ask a parent, "Do you have any firearms in the house?" And they say, "Yes, and they're not locked." I mean, come on! Yknow, so I think access to firearms and medications and things like that.

As mentioned previously, common suicidal behavior and attempt methods are: cutting, stabbing, or self-mutilation; biting; choking, strangulation, or suffocation; hair pulling; hitting, kicking, smacking, or punching self; head banging; and trying to get hit by a car. Therefore, adults should pay particular attention to children's access lethal means related to these methods, such as knives, razors, scissors, or other sharp objects; belts, ropes, plastic bags, shoelaces (as C018 used), or other means of suffocation; and access to busy streets or parking lots. All suicidal children will need specific safety plans that address their unique risk factors, and several treatment providers (P001, P005, P011, P012) discussed individualized safety planning for suicidal children as an important intervention for treatment.

***Collaborate (C).*** The "Collaborate" theme is the fourth step in The RESCUE Model for Childhood Suicidality and it emphasizes the importance of collaboration in treating suicidal children 10 and younger. No one treatment provider will be able to address all of a suicidal child's needs singlehandedly. Instead, it takes many adults to

join together to ensure the best care. The child's parents or caregivers are a very important part of the collaborative team. Many treatment providers (P004, P005, P006, P008, P011) suggested that providers working with suicidal children should provide education to parents regarding the nature of childhood suicidality, the importance of supervision, the importance of limiting lethal means, and how to access local resources. P011 made suggestions for working with parents based on her own experiences. She stated:

...Talking to them about their fears about it. And their ideas about suicide and what they think about it and what do they think about kids being suicidal. And like, because they have- it seems like a lot of the parents have a lot of judgments about it. And they get angry as a defense mechanism to their kid being suicidal. And they don't want to deal with it. So, I think helping them feel more confident and really exploring their own beliefs about it would be helpful.

Adults working with suicidal children can also collaborate with a variety of treatment providers, such as mental health and school counselors, primary care physicians, school nurses, psychiatrists, and other professionals (P007, P008, P009, P010, P011). Again, ongoing stigma about suicide in children might limit other treatment providers' ability to effectively help, so it might be necessary to seek out individuals who have significant experience working with childhood suicidality. In addition, counselors at any developmental level should also seek supervision from their clinical supervisor or consult with a peer who is experienced in childhood suicidality when encountering new cases (P011, P012).

***Understand (U).*** The “Understand” theme is the fifth step in The RESCUE Model for Childhood Suicidality and it encompasses several interventions for addressing suicidal children’s emotions and offering support. The “Understand” title reminds adults to consider the suicidal child’s feelings and to acknowledge that the suicidal child’s feelings are real to them, no matter how trivial they may seem to adults. P005 discussed how giving children a voice is a significant part of the “understanding” process. He described his own interventions with suicidal children in the following quote: “Talking about feelings, sadness, letting them know that their feelings are important and what they say is important.”

One of the most frequent codes under this theme was to help the suicidal child to “find a trusted adult” (P001, P002, P003, P004, P005, P007, P010, P012). Children might first confide in a peer about their suicidal feelings out of fear that their parents will be upset, but other children are unlikely to have the tools or ability to help. Previous research (i.e., Kashani, Goddard, & Reid, 1989) indicated that 86% of parents were not aware of their children’s suicidality. In addition, this study found that family dysfunction, family histories of mental illness & substance abuse, and parenting concerns are triggers for childhood suicidality, so that parents may not be responsible nor have the resources to be there for their suicidal children. This study also found that parents are often a barrier to treatment due to disbelief or denial about their children’s suicidality. Therefore, helping a child to find a trusted adult may be a challenging process in which treatment providers outside of the home are called upon. P004 described the importance of treatment providers making an emotional connection with suicidal children. She stated:

To prevent it from happening again, I think uhm if we had more time for individuals to make a connection, and form an alliance with the kid, and really talk with them about what this means and yknow, what is so bad and how we can work to change things in your life, I think that would probably be the most effective.

In addition, helping the child to relax is an important step of the Understand theme, and many relaxation techniques were suggested in both the interviews (P002, P004) and the treatment charts. Unlike adolescents and adults, children may not have well-developed coping skills, and will require assistance to identify and engage in calming activities. Some examples of relaxing interventions are: having the child blow on their hand, take deep breaths, tap out a beat, write or draw; gentle touching by an adult (such as holding the child's hand or rubbing their back); or offering the child some alone time – assuming they are able to be safe and still have regular supervision.

***Engage (E).*** The “Engage” theme is the sixth step in The RESCUE Model for Childhood Suicidality and it marks the end of steps on what to do when encountering a suicidal child and the beginning of steps to take to begin the therapeutic work to address suicidality. All of the treatment providers interviewed had suggestions for how to engage children in therapeutic work, and there was a great variety of responses present in the treatment charts, as well. P003 explained her views on engaging in interventions. She stated:

I think it's important to know that [suicidality] happens. Uhm, and that it's not like the end of the world, necessarily. And that it is a problem to be solved, like

you have to work on it. And...one thing might not work. Like there's- there might be like lots of different things that you need to try. And just keep trying.

One of the most frequent interventions noted in the treatment charts (applying to 100% of children studied,  $n = 21$ ) was a curriculum called, "I Can Problem Solve," or ICPS. This is a research-based intervention for children in preschool through age 6, which was created by Dr. Myrna B. Shure. This intervention program is utilized in the preschool and elementary partial care programs in which all of the children in the content analysis had participated. It does not specifically address childhood suicidality, but teaches problem-solving skills that may be related to several issues that suicidal children face. P010 noted that ICPS could be adapted specifically for suicidal children. He stated:

ICPS is more about "I Can Problem Solve." So, it's about solving your problems, using terminology, it's about trying to teach- teach those children in a particular age bracket to use their words to express how they're feeling. Uhm...we'd probably have- it'd probably have to be tweaked a little bit for- for kids that are trying to commit suicide. But I don't see why that particular format wouldn't work for children with that age group.

P003, who has utilized the curriculum in a preschool setting noted about ICPS:

I think that definitely helps like it helps like depression- thinking of like lots of different ways to solve your problem, and that- the problem is a problem, and not you. Like, you are not the problem – the problem is the problem, and it's to be solved. So, taking the problem outside of the self. Uhm, really, I think, helps people not be depressed. Uhm, or feel bad about themselves.

The treatment charts showed that 90.91% ( $n = 20$ ) of suicidal children in this study had also received individual counseling in either an outpatient ( $n = 18$ ) or in-home ( $n = 2$ ) setting. The theoretical orientation of treatment providers who offered counseling to the suicidal children was rarely reported in the treatment charts. However, a few modalities were noted. For example, Cognitive Behavioral Therapy (CBT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) were listed. Several treatment providers also discussed modalities of therapeutic interventions for suicidal children. For example, P011 described behavioral interventions, as well as narrative therapy and existential counseling approaches that she used with suicidal children. P009 reported that she used therapy to focus on suicidal children's emotions. She stated:

I think any work that focuses on emotion. Emotion labeling. Recognizing emotions and then learn- I think if we're going- if language is a component of understanding how people are feeling...I think emotion- emotional uhm...therapy that focuses on that emotional development component, social-emotional development, is probably most important. Is *one of* the most important. Depending on the child.

Other treatment providers reported a variety of other treatment modalities, such as the use of sand tray and puppets (P005); journaling (P010); psychoeducation for the child (P011); play therapy (P012); and art, drama, music, movement, and the use of metaphor (P006). P006 specifically stated that talk therapy was not her preferred modality. She stated about suicidal children:

They're not- and especially the pre-logical kid, they're not logical. But they can express how they feel. And you can use whatever mode they're expressing to

kind of react back to them to make it better. You know, to help them heal. Uhm, I think you've got to do a therapeutic dance with them. (Gestures with hands a "dancing" movement.) You know, go where they are! And then just kind of...(Smiles; Gestures with hands a "back and forth" movement.) ...dance with them.

Therefore, many therapeutic interventions may be useful to treat suicidal children. It is important to keep in mind their specific triggers of suicidality and to work towards treating the root cause and not just the symptomatology. P007, a school counselor described her approach to counseling students in the following excerpt:

I will do classroom lessons, I run groups, and I do see kids individually...for a wide range of things. Kids can self-refer. I have a little mailbox on my door where they can just put their name on something and they put it in there and then I'll go and find them. So I work with kids on everything from...I had an argument with my friend out on the playground, can you help us to resolve it? Because this also provides a quiet place where they can do that. So we can do a conflict resolution. It can be someone who's lost a pet or a family member or a parent, or somebody with chronic illness, I mean...it's everything. I usually say that life happens to these guys in the same way that it happens to everybody else.

Since childhood suicidality has not been distinctly studied in the literature, additional clinical studies are needed to determine which treatment modalities and interventions are most effective for children 10 and younger who present with suicidality.

**Barriers to Treatment.** The treatment providers interviewed in this study reported several issues that moderated (and often prevented) the effectiveness of services

provided to suicidal children. The relationship that these barriers have to the treatment interventions can be viewed in Figure 1. Five focused codes were found to be common amongst the data collected from treatment providers, including: difficulty in accurately assessing childhood suicidality; a lack of an assessment tool to assist in diagnosing suicidal children; feeling inexperienced or unprepared to manage suicidal children; encountering myths about suicide in children; and finding parents to be a frequent barrier to treatment. These themes will be discussed in the following paragraphs.

*Assessment of childhood suicidality is difficult.* Interviews with treatment providers showed a theme that assessing and accurately diagnosing childhood suicidality is a difficult process, which may lead to the improper use of interventions or a lack of intervention altogether. P003 explained, “It’s just really hard to know like what actually things are when they’re this young. Like it’s hard to know if it is actually suicidal ideation, or...is it...I don’t know.” P009 described how a lack of professional literature on childhood suicidality might lead treatment providers and other adults to miss the warning signs. She stated:

There isn’t literature about certain things and in this field, so many of the adults have their own ideas of what a child is going through. And that doesn’t mean that I’m correct or they’re correct or anything else, but it is definitely a problem that can prevent us from being able to spot certain things.

P004 also commented on the challenges of assessing childhood suicidality in a hospital setting because not all providers are aware that childhood suicidality is a possibility, or are not aware of the warning signs of childhood suicidality. She stated:

Uhm...like I- and you even read stuff about like accidental ingestions and things like that. Yknow, when you look at the data, it seems like a lot more of those actually end up being the kid saying, “Oh yeah, I was trying to hurt myself,” than not. But a lot of these come through- I think it’s so hard because a lot of come through the ER and might get written up as an accidental overdose or something- accidental ingestion- and get discharged and we don’t ever see that. You know what I mean?

Without guidelines specific to suicide assessment for children 10 and younger, many children may never be identified as suicidal, and therefore, will not have the necessary treatments.

*Assessment tool not available.* All 12 of the treatment providers in this study had never used, and had no access to, an age-appropriate assessment tool for suicidality in children. Several of the treatment providers discussed how they have attempted to adapt their own training experiences on suicidality in adolescents and adults in order to apply them to children, but with little success. P003 stated, “You take what’s appropriate for older- for like adults and adolescents and just kind of try to wing it.” P005 stated of the counseling agency, “We have our own suicide/homicide risk assessment form. But I think it’s all really based off of data that is gathered from working with teens and adults. ...A more specified tool would be helpful.” Finally, P005 described how a lack of an age-appropriate assessment tool might hinder the therapeutic relationship. He stated:

Some of the tools are so long that by the time you get through it- the assessments, I should say, the child it- it’s like- if the kid is in this much pain, do I really want

to ask him all these very cold, specific questions? There's part of me that wants to just screw the assessment and really just sit down and help the kid.

***Treatment provider feels inexperienced.*** All 12 treatment providers demonstrated or voiced a sense of feeling inexperienced or unprepared to serve suicidal children. Despite the fact that the participants had masters degrees in a counseling-related field, had over 1 year of working with a suicidal child or children, and had at least 1 hour of training on the topic of suicide, they all still felt less than experts on suicidal children. Feelings of inexperience included mild discomfort, feeling inadequately trained, and feeling fear and aversion to treating suicidal children. For example, P005 commented on how the topic of suicidal children was confusing. He stated, "There are kids out there that are committing suicide. I don't know enough to know...how or why it's happening." P001 apologized for what he perceived as a lack of knowledge on the subject. He stated:

I'm sorry if it was hard for me to answer some questions. They're tough. They're really tough because again, I don't have any - other than my practical experience like working with kids and experiencing it, there's really nothing out there that I've encountered to say like - Here's how you approach this with kids. - And so it's all just kind of how I've dealt with it in the past or pieces that I've gotten from other experiences.

P003 explained about her experiences in working with suicidal children: "The training I have has mostly been for like adolescents and adults. So, I just kinda make it up as I go along a little bit!" P004 added: "I have to admit, yknow (Pauses; hesitation in voice)...I

feel like I don't- I have experience, but I don't have a ton of experience...And I don't know how helpful I can be.”

Other treatment providers discussed not really knowing how to approach working with a suicidal child, and voiced a need to consult with others on how to manage the situation. For example, P012 stated that she tends to refer a suicidal child to a higher level of care than what she feels comfortable providing in outpatient counseling. The interviewer then asked her what other interventions she might use with suicidal children. P012 paused for 6-7 seconds in the interview, and then replied, “I can’t- I don’t know. Call [my supervisor].” P010 voiced a strong desire to use additional resources to determine the course of treatment for a suicidal child. He stated:

I know for us it’s more uh...talking to our psychiatrists, uh...I think using the resource of the suicide hotline, and uh...you know, would we get on the phone after they’ve talked to the kid to find out what we should do? Uh...a lot of times for us it’s more about getting- getting advice from somebody else.

P011, a clinical supervisor, explained that encountering suicidal children can induce fear for treatment providers of all experience levels. She stated, “Somebody says they want to kill themselves like, even therapists won’t deal with it sometimes because they’re scared...because the potential for somebody to die, they’re scared. They don’t know what to do. It’s a big deal.”

P001 described how the stigma of mental illness and suicidality appears to affect treatment providers negatively. He stated:

I feel like it’s uh...it’s it’s a taboo subject I think to kill yourself. And I think some people have this belief that yknow it’s either, yknow depending what your

moral upbringing is or your background and everything, it could be against yknow your religion to like to even consider that. You know what I mean? I know some people who I've uh grown up with, yknow that's that's something you don't talk about. Suicide is...is not uh...yknow. You commit suicide you go to hell. You know what I mean? So, I think that's a piece of it, too. It's like it goes against some of the morals and values that some people have. Uhm...And I think it makes us, again it just makes us uncomfortable because it's – when somebody says that, you're really like exposing like yknow a side of yourself that a lot of people aren't- don't know how to respond to. You know what I mean? Like when you say that, you're telling somebody, "I'm really hurting and I'm really in in some emotional pain." And uh I think it's hard for some people to empathize with that and sympathize with that. Because maybe some people haven't felt that, uhm that could be a piece of it. But uhm...And it's scary. Death is a scary thing to all of us. ...I think therapist, clinician, or not, it's a scary thing to think about.

Combining the taboo subject of suicide with a population of children 10 and younger appears to compound treatment providers' fear. P008 described a situation in which she encountered a suicidal child and reacted with aversion.

Only once did a child say it in a session and then I thought I needed to follow up from there. That child was very young. And it was very hard to figure out exactly what was leading to the statement. So that made it hard. ...It was like, "I want to kill myself. I want to cut my legs off. I would use a knife. I would get it from..." Like, and like where he would get the knife from. And I was like, (Gestures with both hands palms out, like "Stop.") "Okay! Wow. Way too many

details. And, (Whispers.) Let's just get it checked out!" (Chuckles.) You know?

Better safe than sorry, sort of thing.

P008 went on in the interview to describe many positive interventions and methods for working with suicidal children, but in this description of encountering a suicidal child, it seemed that her personal fears may have inhibited her helping response. Overall, treatment providers' sense of fear and inexperience was a significant barrier to serving suicidal children.

***Myths about suicide in children.*** Treatment providers also reported that myths about children's suicidality affected their ability to effectively serve suicidal children or to team the treatment with other providers. It was frequently reported that the treatment providers encountered other potential helping professionals who simply did not believe that children could experience suicidality. For example, P003 stated, "We've had mobile response workers who say that we don't- that our kids- they're like, 'Oh no, that's too young. We can't have mobile response for that young of a kid.'" Similarly, P008 reported, "I've had uhm resistance from parents, from administrators, from hospital staff, in taking a child under ten's statements as factual." P008 stated, "People assume like...what 8 year old is actually going to kill themselves?" P010 also encountered this issue, and stated:

Even in this field sometimes- and depending on who it is, I could have a hard time figuring out, "Okay, how am I going to react to this particular kid?" ...and stuff like that. Because again, you know, most people are like, "Why would you want to hurt yourself?"

P004 described how current prevention and intervention strategies seem only to target individuals because of the general public's deep-seated mythology about suicide. She stated:

So, I think it is a very very taboo thing and yknow, getting to kids who are in need of help is difficult just from the standpoint of like the general population. (Uses a lower voice.) "Because you might make things worse if you talk about something like that in class to an entire group." (Returns to regular voice.) You know what I mean? Like, it- you really need to- we need some better way to identify individuals at risk...to be able to intervene there rather than kind of like on a higher level. You know what I mean?

P007 added about suicidality, in general: "I think we're still working on getting to the point where we believe...it's not going to happen just because we mentioned it. We're not going to suddenly give them some idea that wasn't...there before." These myths about childhood suicidality have the potential for leading to a reactive instead of proactive approach to managing the issue, and makes it more challenging for treatment providers to provide collaborative services for suicidal children.

***Parent as a barrier to treatment.*** Parents were cited in 9 out of 12 interviews with treatment providers as being a barrier to treatment for their suicidal children. While parents can potentially be significant partners in helping their child decrease their suicidality, it often turned out that parents were often unwilling or unable to assist. As P009 pointed out, this trend applied to biological parents and foster or adoptive parents. P002 described the different responses from parents as a "fifty-fifty split," meaning that about half of the parents she had encountered were helpful and appropriately responsive,

while the other half were not. P006 shared an example of one parent who was helpful in her child's treatment, and stated:

His parent is an adult who's very able to follow the thread here. And, yknow, she really is able to uhm really advocate to keep him safe- keep him alive while we figure out what the heck's going on here. And keep everybody else around him safe.

Unfortunately, most of the other providers gave examples of parents who were less than helpful in the treatment process for their suicidal children. P008 explained that some parents also simply do not believe that their child could be suicidal. She described one female elementary school student who had cut her wrists with razor blades:

And the mother said, "No, I know my daughter. She would never do that." And things like that. And I'm like, "But we absolutely have to have this checked out." And the mother was so angry with me for even implying that this could be a possibility. Just total denial. No way. "Okay, but she came in with razor blade cuts...And this is what she said, clearly. I didn't lead her to that statement. And she even said it to the teacher, too. (Pauses.) I just want to make sure your kid's okay..." is really, yknow, my viewpoint at that point.

Other treatment providers found that parents seemed disinterested in helping their children become stabilized. As P001 stated, "I find the most difficulty in working with the parents on how to be supportive and how to help their child when they leave this building." Similarly, P003 stated, "I feel like- a lot of times parents are looking for like magic fixes. Like, the answer, the diagnosis that's going to solve everything. And that's

never the case in my experience.” Finally, P004 stated, “There’s parents who want a medication and only want a medication to fix things, which doesn’t happen.”

## **Conclusion**

This study sought to answer three research questions regarding the characteristics of suicidality in children 10 years and younger, the factors that influence childhood suicidality, and the treatment implications for suicidal children. First, this researcher found it important to address that childhood suicidality is indeed a real phenomenon. Children can and do feel suicidal, as evidenced by the core category that interpreted that children are capable of experiencing the full spectrum of suicidality, regardless of their understanding of the meaning or finality of death. Childhood suicidality can first present in preschool or elementary school, and does not require verbalization. Children infrequently have well thought-out suicide plans and may have low intent to end their lives, although they may frequently engage in dangerous behaviors that may have death as a consequence.

Next was the question regarding characteristics of childhood suicidality. It was found that childhood suicidality can be directly observed by many qualities, such as: impulsivity, crying or sadness, homicidality, aggression, mood swings, poor social or communication skills, elopement, oppositional defiance, irritability, tantrums, isolation, urination in inappropriate places, theft, low self-esteem, risky behaviors, and poor self-care. It was found that children’s suicidality for the purpose of attention-seeking only is an incorrect assumption. Specific suicidal behaviors that were most common in this sample of children were: cutting, stabbing, or self-mutilation; biting self; choking,

strangulation, or suffocation; hair pulling; hitting, kicking, or punching self; head banging; and trying to get hit by a car.

Then, the researcher sought to interpret the factors that influence childhood suicidality. It was found that a complex interaction of triggers was common for most of the children studied. Many children had experienced severe traumas, such as: separation from a primary caregiver, abuse (including emotional, physical, and sexual types), neglect. Other trauma and stressors included low SES, general trauma from life experiences, and general stressors, such as from school. An additional set of triggers included negative familial influences, such as family dysfunction (including domestic violence in the home); a family history of mental illness, substance abuse, or suicidality; and parenting concerns or involvement with DCP&P. Childhood suicidality seemed most related to the following mental health diagnoses or conditions: ADHD, Adjustment Disorder, psychosis, Mood Disorders, Oppositional Defiant Disorder, and PTSD. Childhood suicidality was also related to the following physical health diagnoses or conditions: poor sleep or insomnia, asthma, enuresis, ear tubes or frequent ear infections, and seasonal or environmental allergies.

Finally, the researcher sought to determine best practices for treating suicidality in children 10 and younger. It was found that treatments for suicidal children varied widely and were dependent upon the triggers for children's suicidality. Common psychiatric interventions that were discussed for treating childhood suicidality were: crisis screening, psychiatric hospitalization, and psychotropic medications. The RESCUE Model for Childhood Suicidality was created to serve as a framework for treatment providers and other adults encountering suicidal children 10 and younger, and included the following

six steps: Respond, Evaluate, Safety, Collaborate, Understand, and Engage. Five barriers to the effective treatment of childhood suicidality were also found, including: the difficulty of assessing childhood suicidality; not having an age-appropriate assessment tool; treatment providers who feel unprepared or fearful about working with suicidal children; myths about suicide in children; and parents who are not helpful in assisting with their child's treatment.

## CHAPTER FIVE

### DISCUSSION

The purpose of this study was to explore the topic of children's suicidality and to determine the characteristics of suicidality in children 10 and younger, to learn what factors influence childhood suicidality, and to identify treatment implications for suicidal children. A qualitative, grounded theory methodology was utilized, and the researcher engaged in purposive sampling, which began at a large not-for-profit mental health counseling agency in New Jersey. Then, the researcher completed a total of 12 semi-structured interviews with treatment providers who were experienced in the field of children's suicidality, as well as a content analysis of 22 closed treatment charts of children who had been identified as suicidal at 10 years old or younger. A research team was employed for simultaneous data analysis, which included consensus coding of data derived from interview transcriptions and the treatment charts.

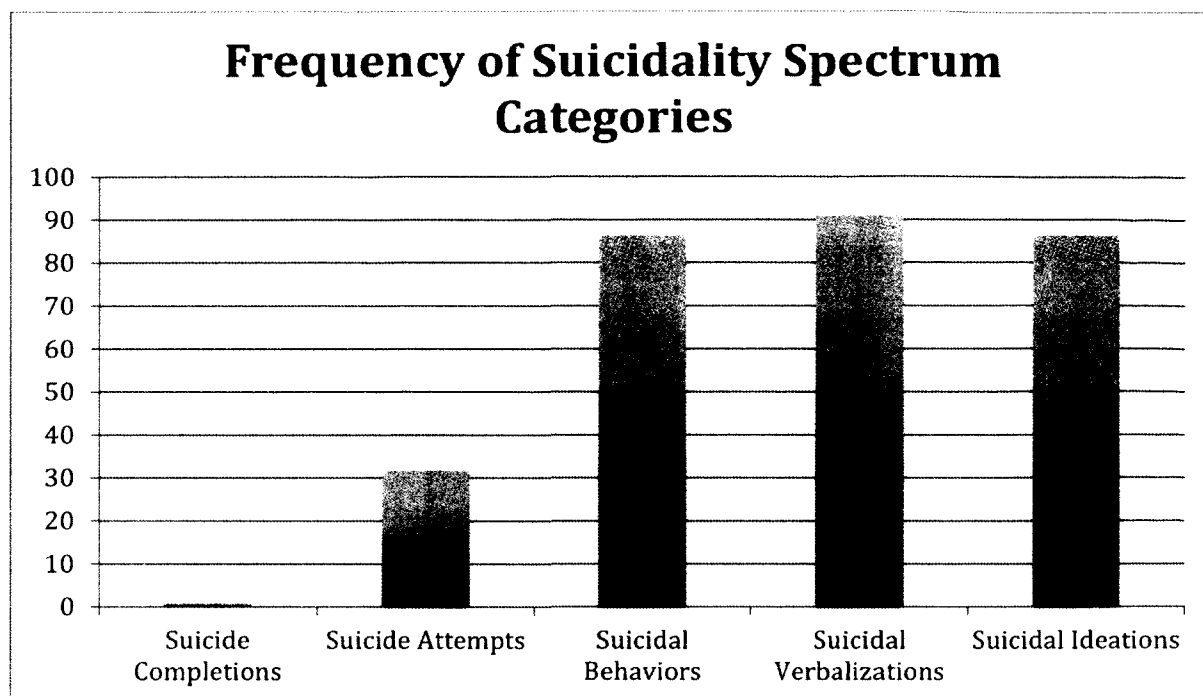
This study identified 4 axial and 21 open codes regarding the core category childhood suicidality (including suicidal ideation, verbalization, behaviors, and attempts, and the observable qualities of suicidal children); 6 axial, 15 focused, and 5 open codes regarding causal conditions of childhood suicidality (including abuse & neglect, separation from primary caregiver, other trauma & stressors, negative familial influences, and related mental & physical health diagnoses); and 1 axial, 3 focused, and 1 theoretical code regarding treatment implications for treatment providers and other adults who encounter suicidal children (including specific interventions and common barriers to effective treatment). A final axial code, barriers to treatment, was found to moderate the effects of treatment interventions. This chapter will discuss the findings of the research

study, compare these findings to existing literature on children's suicidality, and describe implications for theory and practice. Finally, this chapter will explain the limitations of the study and describe directions for future research.

### **Core Category of Childhood Suicidality**

This study found 4 axial codes regarding the nature of suicidality in children 10 and younger, including the presence of the full spectrum of suicidality (suicidal ideation, verbalizations, behaviors, attempts, and completions) among children, despite limitations in understanding the meaning and finality of death. Completed suicides were only discussed in the interview with P006, who had worked with chronically ill children in a hospital setting, and were not present in the content analysis. This is consistent with existing statistics that describe childhood suicidality as a fairly infrequent phenomenon (WHO, 2010). However, as Cheng et al. (2009) described, suicide attempts are much greater than actual completions. In this study, 31.82% ( $n = 7$ ) of the children studied had experienced suicide attempts. Moving across the spectrum of suicidality in decreasing lethality, this study showed greater numbers of suicidal children that displayed suicidal behavior, verbalizations, and ideation than suicide attempts or completions. Figure 2 below shows this trend.

Figure 2.

*Frequency of Suicidality Spectrum Categories*

This trend is consistent with the literature that indicates suicidal ideations are much more common than suicide completions (Fite, Stoppelbein, Greening, & Preddy, 2011).

P004 described her experiences working in a hospital-based screening center, and noted how screening for suicidality in children is generally done poorly because the staff (medical personnel and crisis screeners) do not always think to ask about suicidality in cases that may appear to be related to physical health, such as cases of ingestion or overdose by children. As previous authors have noted, reporting error, stigma about suicide, and denial of childhood suicidality have affected estimations of the prevalence of childhood suicidality so that they appear lower (Davis, 2004; Shamoo & Patros, 1997). This study showed that there are certain conditions, such as specialized foster care

(discussed by P005 and P009) in which children's suicidal ideation can be as high as 50%. Due to the traumatic nature of circumstances which might have led to specialized foster care, it is not surprising that suicidal ideation is this high, when previous research has estimated that approximately 37.9% of the general population has experienced suicidal ideation by the time children reach high school (Skala, Kapusta, Sclaff, Unseld, Erfurth, Lesch...Akiskal, 2012). A child's presence in specialized foster care implies that there have been abuse or neglect issues in the family, in combination with concerns about the child's mental health and well-being, which have independently been shown to be triggers for childhood suicidality (and will be discussed later in this chapter).

Additional axial codes for this category regarding the nature of childhood suicidality included an onset in preschool and elementary school-aged children. The content analysis showed that 40.91% ( $n = 9$ ) of suicidal children had an onset of symptomatology at ages 3 or 4, and 59.09% ( $n = 13$ ) had an onset at ages 5 through 10 years. This data challenges the myth that very young children cannot be suicidal, and emphasizes the call for interventions in preschool and kindergarten that other researchers have made (Barrios, Sleet, & Mercy, 2003; Fite, Stoppelbein, Greening, & Preddy, 2011; Zenere & Lazarus, 2009). In addition, P009 discussed symptomatology of suicidality that began in infancy, such as not wanting to communicate, not responding to verbal cues, refusing to make eye contact, and not engaging in proximity-seeking behavior with others. Shamoo and Patros (1997) had discussed infant depression, but this study may be unique in suggesting suicidality in infants. Another unique outcome of this research was the subtheme, "suicidality does not require verbalization." This implies that children 10 and younger who experience suicidality, especially suicidal ideation, may not verbalize

these thoughts to others. Unfortunately, this lack of verbalization implies that adults will have to be more attentive to other risk factors or warning signs of childhood suicidality, and will have to be responsible for initiating conversations with children regarding the topic of suicidality and their related feelings.

It is a common misconception that children 10 and younger are incapable of understanding the meaning and finality of death, and therefore are unable to willingly engage in suicide and related behaviors (Davis, 2004). Some researchers have posited that the age that most children are able to comprehensively understand suicidality and death is 10 years (Dervic, Friedrich, Oquendo, Voracek, Friedrich, & Sonneck, 2006). However, this study explored the cases of 22 children who were actively suicidal (including the spectrum of thoughts, behaviors, and attempts) prior to age 10, with onsets from age 3 to 9 (the mean was 5.67 years). Regardless of their understanding of death, many of these children engaged in suicidal behaviors so severe that 7 of them required inpatient hospitalization. One child in particular, C001, an African American male, had been hospitalized 7 times by the time he was 6 years old, and had engaged in the following behaviors to try to end his life: running into traffic, trying to jump out of a 3<sup>rd</sup> floor window, trying to suffocate himself with a plastic bag, cutting and stabbing himself with sharp objects and glass, and other self-harming behaviors. Another child in this study, a Caucasian female, had tried to hang herself with a shoelace at age 3. Regardless of these children's understanding of the concept of death, they engaged in behaviors so dangerous that they could have ended their lives.

In addition, P006 described the chronically ill children that she served in her previous role as a nurse, and explained that this population had absolutely understood the

finality of death because they had witnessed the deaths of many of their peers from the hospital. Therefore, when they engaged in suicidal behaviors or attempts, it was with full understanding that they would never wake up. For these chronically ill children, however, the escape from a life of pain, and hospitals, and grief, sounded better than their everyday reality. This study found that both children who had a fully developed concept of death and those who did not had the ability to experience and engage in the full spectrum of suicidality.

Additional axial codes regarding the nature of suicidality in children were a “low intent to die” and a “low frequency of suicide plans.” This study showed that only a small percentage of suicidal children (23.81%) had reported a serious intent to end their lives and only 9.52% had created a suicide plan. As one explanation for these findings, P004 alluded to the overuse of suicidal verbalizations as a cliché method of voicing frustration when she described one child who said he wanted to kill himself to avoid having to clean his room. This statement indicates no plan or desire for him to end his life.

Another explanation might be that children actually do not want to end their lives, but they do not know any other way to escape the traumatic situation in which they have lived. P011 discussed symptom relief as a motivating factor for childhood suicidality. When one explores the factors that influence childhood suicidality, such as physical and sexual abuse, dysfunctional home environments, and separation from a primary caregiver (to be discussed later in this chapter), it seems impossible for a child to be able to cope normally under these extreme circumstances. They might not have planned a way to die because they were lacking planning skills at their young age, or because they were able to

tolerate the negative situation to a certain point until they suddenly realized they could not tolerate it anymore. Although it was not measured in this study, it may be that children have a low intent to die but a high desire to escape from trauma and chaos. Mazza (2006) suggested that children choose methods of suicide that have low lethality and a high chance of rescue. This relates to the discussion because Mazza acknowledged a similar debate: do children not want to die or do they simply have less access to lethal means?

The final axial code regarding the nature of childhood suicidality was a quality that the suicidality was consistent or ongoing. It does not seem that duration of childhood suicidality has been discussed in past literature. The children in this study demonstrated ongoing symptomatology of suicidality for years, and some participants described presentations of suicidality as “cyclical” (P001, P011). This may represent the pervasive nature of the triggers for childhood suicidality (e.g., abuse that continues for a long time, or a family history of mental illness which will not go away), a lack of effective treatment for childhood suicidality, or that childhood suicidality is simply a long-lasting problem. The ongoing quality of childhood suicidality will require future research.

**Observable qualities of suicidal children.** This study found 17 open codes related to the observable qualities of suicidal children 10 and younger. These qualities included: impulsivity, crying or sadness, a relationship to homicidality, aggression, mood swings, poor social or communication skills, running away or elopement, oppositional defiance, irritability, tantrums, isolation, urination in inappropriate places, theft, low self-esteem, generally risky behaviors, and poor self-care. The final code was, “attention-seeking is an incorrect assumption.”

Several of these qualities align with past research findings regarding suicidal children and adolescents. For example, Davis (2004, citing from multiple past sources; See: Helsel, 2001; who cited from Capuzzi, 1994; Jackson, Hess, and van Dalen, 1995; Paykel, 1991; Popenhagen and Qualley, 1998; and Range, 1993) provided a compiled list of “Signs and Symptoms of a Suicidal Child,” which included the qualities of: isolation, risky behaviors, acting-out behavior (similar to tantrums), running away, periods of depression (which may include crying or sadness), oppositional defiance, poor self-care, and mood swings. However, this study may be the first to provide empirical evidence for these qualities because the abovementioned citations were largely conceptual. Fite, Stoppelbein, Greening, & Preddy (2011) discussed the relationship between suicidality and low-self esteem. Finally, Holtman, Buchmann, Esser, Schmidt, Banaschewski, & Laucht (2011) reported symptoms of “severe affective and behavioral dysregulation, including irritability, aggression, ‘affective storms’, hyperarousal and mood instability.”

Unique to this research study (after finding commonalities in past literature for 11 of the codes), are six remaining open codes: impulsivity, a relationship to homicidality, poor social or communication skills, urination in inappropriate places, stealing or theft, and attention-seeking as an incorrect assumption. It might be that these remaining open codes are unique to children’s suicidality (as separate from adolescents and adults), that they are new concepts for suicidality research, or that they simply related to the sample of children included in the content analysis and discussed in the interviews with treatment providers. Each one of these codes will be described in the following paragraphs.

***Impulsivity.*** There is a great deal of evidence from this study that suggests that impulsivity is a characteristic of childhood suicidality. 76.19% ( $n = 16$ ) of the children

from the content analysis displayed impulsivity and 10 of 12 treatment providers discussed impulsivity as characteristic of suicidal children. However, 76.19% of the sample had also been diagnosed with ADHD, and impulsivity is also a characteristic of this diagnosis (APA, 2013). Regardless of the overlap, it would be logical to assume that impulsivity is a risk factor for childhood suicidality.

***Homicidality.*** There is also a great deal of evidence from this study that suggests that homicidal ideation, threats, or behaviors are related to childhood suicidality. In fact, P009 described being unable to distinguish childhood suicidality from homicidality and harm to animals, at times. It is frightening to think that children might be able to cause harm to themselves and to others, but it is certainly something that parents and treatment providers should be aware of when working with a suicidal child.

***Poor social or communication skills.*** Children generally have poorer social and communication skills than their older counterparts due to their developmental level. However, suicidal children might be even more at risk if they are unable or unaware of how to express their feelings of pain, sadness, or anger. This code may apply to children who are developmentally delayed due to physical or mental health diagnoses (such as a communication disorder or perhaps an Autism Spectrum Disorder), traumas (such as a traumatic brain injury), or neglect (such as not being spoken to or provided for by adults). Treatment providers may need to adapt traditional verbal assessment measures for suicide to meet the needs of children with limited social and communication skills, and also provide services using a modality that the child can utilize (such as art or play).

***Urination in inappropriate places.*** The code of urination in inappropriate places may have a variety of different reasons as to why it was so common (33.33%) among the

suicidal children in this study. Urinating on the floor or on other people may be one way of expressing anger in a situation where the child has little control. Enuresis, or the inability to control urination, has also often been linked to sexual abuse, which did affect 31.82% of this group of children. However, Forbes (1998) stated:

While acknowledging the link between enuresis and sexual abuse, it is important to recognise that there are children who present with “simple” enuresis, with no other associated features of psychological disturbance.

Therefore, the urination in inappropriate places is a code that requires additional research in its relation to childhood suicidality.

***Stealing or theft.*** Stealing or theft is another code that does not seem exactly related to childhood suicidality, but occurred in 33.33% of the treatment charts of suicidal children. Stealing might be a behavior that can simply be categorized as “acting out” to express anger or frustration, it might reflect upon the children’s low socioeconomic status, or it may have another relation altogether to childhood suicidality. This code also requires additional research.

***Attention-seeking as incorrect assumption.*** The researcher intentionally included attention-seeking as a category of the treatment chart data collection form (see Appendix A-5) to evaluate the myth of suicidal children who are only seeking out attention from adults. Only 13.64% of treatment charts discussed any sort of attention-seeking behavior by the suicidal children. It is logical, then, to assume that children who verbalize or demonstrate other forms of suicidality are not only looking for attention. This subtheme also indicates that it is essential for adults to take all signs of childhood suicidality seriously and investigate further when suicidality is observed.

**Most frequent methods of suicidal behaviors and attempts.** This study found 7 open codes which identified specific behaviors and suicide attempt methods common to suicidal children, including: cutting, stabbing, or self-mutilation; biting self; choking, strangulation, or suffocation; hair pulling; hitting, kicking, smacking, or punching self; head banging; and trying to get hit by a car. All 7 codes regarding methods of suicidal behaviors and attempts in children were represented in past literature. Methods of suicide attempts for children 10 and younger have not been specifically collected by the CDC, but the most common methods for youth ages 10 to 24 were reported as: firearms (45%), suffocation (40%), and poisoning (8%) (CDC, 2012). Mazza (2006) discussed that young children typically do not have access to lethal means and may resort to other creative means to cause harm, such as holding their breath, head banging, or running out into traffic. Davis (2004) discussed a range of self-injurious behaviors, which included several behaviors identified in this study, such as: cutting, biting, hitting, and pulling hair.

Barrocas, Hankin, Young, and Abela (2012), studied 665 children ages 7 through 16, and described that self-injurious behaviors, such as those described above, should be considered “nonsuicidal self-injury,” or NSSI. Other researchers (e.g., Klonsky and Olino, 2008) have worked to distinguish self-injurious behaviors as related to suicidality or NSSI. This study found that 90.91% ( $n = 20$ ) of treatment charts described children who self-injured, and 100% of those children also displayed suicidal ideations and/or verbalizations. In addition, 31.82% ( $n = 7$ ) of the sample also engaged in overt suicide attempts. Therefore, this study found that self-injurious behavior was strongly related to suicidality, but additional research is necessary to further explore these findings.

### **Causal Conditions of Childhood Suicidality**

This study found 6 axial codes representing life events or conditions that seemed to strongly influence childhood suicidality, including: abuse (including emotional, physical, and sexual) and neglect, separation from a primary caregiver, other trauma & stressors, negative familial influences, mental health diagnoses, and physical health diagnoses.

All of the axial codes related to abuse and neglect are well-documented in the literature as potential triggers for suicidality, especially sexual abuse (Andover, Zlotnick, & Miller, 2007; Dervic et al, 2006; Hawton & Harriss, 2008; O'Connell, 2012; Pomerantz, Gittelman, Farris, & Frey, 2009; Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008). Separation from a primary caregiver by out-of-home placement has been previously shown to increase suicidal ideation by 500% (Rhodes et al., 2012). In this study, 86.36% of suicidal children had experienced suicidal ideation and 73.68% of the children with suicidal ideation had been separated from a primary caregiver.

Additional traumas and stressors have also previously been discussed in the literature. Low SES, although not a predictor for psychiatric disorders, has been found to be associated with suicidality and limited access to healthcare (Fite, Stoppelbein, Greening, & Preddy, 2011; Foley, Goldston, Costello, and Angold, 2006; Holtmann, Buchmann, Esser, Schmidt, Banaschewski, & Laucht, 2011). The general traumas related to childhood suicidality do not only affect the children, but can also impact the adults who encounter suicidal children. For example, three of the treatment providers interviewed for this study (P006, P009, and P0011) described experiencing secondary, or vicarious trauma, that they personally had experienced from working with suicidal

children. Their interviews were quite emotional and all three of the participants spoke in serious tones about the traumas that the children they served had survived. For example, P009 described a young girl whose mother threatened to kill her and held a knife to her throat. Later on, the same girl was sexually assaulted, and she reacted to this event by disfiguring her own genitals. P009 also spoke about a young boy that was frequently beaten and even burned by his father. The child was then displaced from his family and forced to use an Americanized version of his name. P009 described that after years of working as a mental health counselor, she had to leave the field because it became too overwhelming. The traumas that these children faced were real and scary, and they often had no control over any of their life circumstances, except perhaps to stop living.

**Negative Familial Influences.** There were 5 open codes related to negative familial influences that were strongly related to childhood suicidality, including: family dysfunction, a family history of mental illness, substance abuse, or suicidality, parenting concerns or involvement with the Division of Protection & Permanency (DCP&P). Many of these subthemes were found in existing literature on suicidality. For example, family dysfunction was very frequently cited as a factor that influences suicidality (Asarnow, Carlson, & Guthrie, 1987; Cheng et al., 2009; Dervic et al., 2006; Fernquist, 2000; Hawton & Harriss, 2008; O'Connell, 2012; Pomerantz, Gittelman, Farris, & Frey, 2009). A family history of suicidality was also shown in previous studies to affect biological children, especially amongst primary relatives (Dervic et al, 2006; O'Connell, 2012; Qin, Agerbo, & Mortensen, 2002; Rajalin, Hirvikoski, & Jokinen, 2012). In addition, there are 3 subthemes that were not explicitly discussed in past literature, and they will be described in the following paragraphs.

***Family history of mental illness.*** Some previous literature has described a familial relationship regarding depression, some of which may be biologically transmitted (Bondy, Buettner, and Zill, 2006). However, other familial mental illnesses were not discussed. This study showed that 100% of suicidal children had a family history of mental illness, substance abuse, or both. Not all families with mental illness had members who had experienced suicidality. In fact, 76.19% of the sample had familial histories of mental illness, and only 33.33% had familial histories of suicidality. Therefore, children did not simply mimic suicidal behaviors that they had seen at home. Family members diagnoses ranged significantly, and included: ADHD, anxiety, Autism, Bipolar Disorder, Borderline Personality Disorder, depression (including postpartum depression), Dissociative Identity Disorder, PTSD, Schizoaffective Disorder, and Schizophrenia. Influences of familial mental illness should be explored future in future research.

***Family history of substance abuse.*** A very large number of suicidal children in this study (85.71%) had families with substance abuse histories. Not only were children often witness to their parents' and relatives' drug use, but 4 children were themselves exposed to drugs in utero, and 3 children were born physically addicted to drugs. While familial mental illness may not be a controllable factor when considering prevention of childhood suicidality, substance abuse is a factor that can be eliminated with responsible planning and parenting. The exact relationship between substance abuse and childhood suicidality is not yet known, but should be explored in future research.

***Parenting concerns or involvement with DCP&P.*** This subtheme, parenting concerns or involvement with DCP&P, generally combines traits of several other

subthemes, such as abuse, neglect, separation from a primary caregiver, family dysfunction, and possibly parental mental illness and substance abuse. The reason that this subtheme remained distinct, however, was because it includes an easily identifiable, yet at-risk population to track. 81.82% of the suicidal children in this study had a history of parenting concerns or DCP&P involvement. According to the State of New Jersey and the Department of Children & Families (2014), there were 51,864 children and adolescents under age 21 involved with DCP&P as of June 2013 (the most recent data available). Roughly 65%, or 33,712 of those children (using statistics from December 31, 2012) were ages 0 to 10. This number represents a population of children who are extremely at-risk for childhood suicidality.

To explore compound triggers for childhood suicidality, approximately 4,783 children were involved with DCP&P, were in out-of-home placements (or removed from their primary caregiver), and – as evidenced by their removal – likely had substantiated histories of abuse or neglect. This number represents a population of children who are at even higher risk for childhood suicidality. It is important to remember that this population of children are known to treatment providers because of their involvement in the mental healthcare system, and that this is a population that requires special attention and care. However, there are still unknown numbers of children who have not yet been identified, and who are at risk for childhood suicidality, as well.

**Related mental health diagnoses.** This study found 6 mental health diagnoses or conditions to be related to childhood suicidality, including: ADHD, Mood Disorders, Adjustment Disorder, PTSD, Oppositional Defiant Disorder (ODD), and hallucinations or psychosis. Mood Disorders, including depression and Bipolar Disorder, have long been

associated with suicidality for all age groups (Ben-Yehuda et al., 2012). Interestingly in this study, the Mood Disorders (57.14% of the sample) were second to ADHD (76.19%). There is a possibility that depressive symptomatology in the children included in this study was misdiagnosed as ADHD. However, a diagnosis of ADHD has also been linked to childhood suicidality (Ben-Yehuda et al., 2012; Hinshaw et al., 2012). ADHD-related impulsivity was also reported to put children at high risk for suicidality, especially for girls. Adjustment Disorders and Conduct Disorder (to include ODD) have also been discussed in the literature (Ben-Yehuda et al., 2012; Mazza, 2006). Mazza (2006) also discussed schizophrenia as a diagnosis related to suicidality. As mentioned in the literature review, schizophrenia is not typically diagnosed until early adulthood. However, hallucinations or psychosis may be present in children, which was also evident in this study. PTSD was the only mental health diagnosis subtheme that was not found in past literature, although several studies have described traumatic factors (such as physical and sexual abuse) as being related to suicidality (Andover, Zlotnick, & Miller, 2007; Dervic et al., 2006; O'Connell, 2012; Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008; Zapata et al., 2012).

**Related physical health diagnoses.** This study found 5 physical health diagnoses or conditions to be related to the sample of suicidal children in the content analysis, including: poor sleep or insomnia, asthma, enuresis, frequent ear infections or ear tubes, and seasonal or environmental allergies. Davis (2004) found that “reported changes in eating in sleeping patterns” (which would include poor sleep or insomnia) were related to childhood suicidality (p. 216). Also, as discussed previously, enuresis might also be related to suicidality and is a topic for future research. Asthma, frequent

ear infections or ear tubes, and seasonal or environmental allergies were not found in the literature as related to suicidality. These conditions may have been more frequent in the sample for unrelated reasons, but occurred frequently enough so that they may benefit from additional research.

Finally, this discussion of childhood suicidality and its many causal conditions reflects that a complex interaction of triggers make childhood suicidality difficult to understand.

### **Treatment Implications for Suicidal Children**

Treatment implications for childhood suicidality included suggestions for counseling interventions and psychiatric interventions (including crisis screening, psychiatric hospitalization, and psychotropic medication). These interventions can and should be used simultaneously, as necessary. For example, a child can be treated through individual counseling and psychotropic medication, and past literature has shown that combination therapy is often more effective than medication or talk therapy alone (see Dongfeng, Zhang, Zhang, & Li, 2014 for a study on combination therapies for Major Depressive Disorder in children and adolescents). This section will also discuss barriers to treatment that affect treatment effectiveness and The Rescue Model for Childhood Suicidality, which was introduced in Chapter Four.

**Counseling interventions.** Literature on the treatment of childhood suicidality is extremely limited. Davis (2004) provides one of the only guides to treating suicidal children ages 5-12, and while quite thorough, it is a conceptual rather than a research-based book chapter. Tamas et al. (2007) recommended interventions that focus on increasing a child's adaptive emotional regulation strategies, but did not suggest specific

steps or interventions to do so. McDougall, Armstrong, and Trainor (2010) emphasized that all treatment strategies should be collaborative and multi-modal, and stated, “No single approach is likely to be effective in addressing what is a large-scale universal problem” (p. 192). Due to the lack of literature on treating suicidal children, this study sought to explore treatment implications from treatment providers and the content analysis of closed treatment charts. Research on specific counseling interventions and theoretical orientations, such as Cognitive Behavioral Therapy (CBT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is needed to explore their effectiveness in application for childhood suicidality.

**Psychiatric interventions.** This study found 3 focused codes related to psychiatric interventions for treating childhood suicidality, including: crisis screening, psychiatric hospitalization, and psychotropic medication. The codes of crisis screening and psychiatric hospitalization have been discussed in previous literature. For example, studies have shown that children with suicidal ideation and behaviors have been increasingly visiting hospital emergency rooms for screening and treatment (Horowitz, et al., 2001; Pompili, Mancinelli, Giardi, Ruberto, & Tatarelli, 2004). In addition, Flannery (2006) noticed obstacles to psychiatric hospitalization for suicidal children, which included untrained hospital staff, strict insurance regulations, and a limited number of beds for children’s psychiatric needs.

Literature regarding psychotropic medications for childhood suicidality is limited because as P004 described, psychiatrists prescribe medications to treat certain symptoms, such as impulsivity or aggression, instead of treating the whole issue of suicidality. She stated: “If it’s depression, I mean, guidelines are for us to treat with SSRIs.” Overall, the

participants in this study had mixed opinions about psychotropic medications prescribed for children, which seemed to represent a larger controversy regarding pharmaceuticals in the United States. Although medication alone generally has less favorable outcomes than medication plus counseling interventions, interviews with treatment providers indicated that parents of suicidal children are looking to quickly resolve their child's issue with medication and no other interventions at all (P003, P004).

**Barriers to treatment.** This study found 5 axial codes related to barriers to effective treatment for suicidal children, including: the assessment of childhood suicidality is a difficult task, there is a lack of access to an age-appropriate assessment tool, treatment providers feel inexperienced, there are ongoing myths and stigma about suicidality in children, and parents can be barriers to treatment. Given the lack of professional literature and treatment tools for the specific topic of suicidal children 10 and younger, it is not surprising that treatment providers have encountered many barriers to providing effective services to this population. Several of the barriers found in this study also align with existing literature. For example, Mishara (1999) described how myths about suicide, namely that children are unable to understand death and therefore cannot be suicidal, can affect both the public and helping professionals' opinions about suicidal children, and leads to the misconception that childhood suicidality is not a pressing issue.

**The RESCUE Model for Childhood Suicidality.** The RESCUE Model for Childhood Suicidality encompasses the majority of findings related to treatment for childhood suicidality and gives treatment providers and other adults a step-by-step guide for when they encounter suicidal children. Past models, such as the "IS PATH WARM"

mnemonic by the American Association of Suicidology (n.d.), only provides information on suicide warning signs – not treatment implications – and is not based on childhood suicidality. The American Foundation for Suicide Prevention ([AFSP]; 2014) also provides information on risk factors and warning signs of suicidality and additionally provides information on how to find resources and treatment options, but does not specifically address childhood suicidality. The AFSP (2014) – and most other suicide resources – recommend that suicidal individuals find a mental health treatment provider to start treatment. Gasior and Underwood (2011) for the Society for the Prevention of Teen Suicide [SPTS], wrote the following to help parents navigate the potentially confusing degrees and credentialing of outpatient therapists:

From a practical viewpoint, it does not matter which degree or letters therapists have after their names; they are all trained to provide clinical care in the community. What matters is how comfortable you and your family member feel with them.

While families of suicidal children should seek professional help to address childhood suicidality, this research identified treatment provider's sense of inexperience as a significant barrier to effective treatment. 100% of the treatment providers in this study demonstrated a sense of inexperience and un- or under-preparedness for working with suicidal children, despite their "expert" status and years of experience (mean = 8.83 years) providing treatment to the population. While all treatment providers had educational degrees and other credentials that would indicate to the layperson (such as the parent of a suicidal child) that they were qualified to treat children with all mental health issues, including suicidality, the findings of this study suggest that childhood

suicidality is an area in which treatment providers feel a lack of confidence and competence. Future research is needed to address how treatment providers can be better prepared to work with suicidal children.

### **Implications for Practice and Future Research**

Children's suicidality is an issue that is not yet understood by treatment providers, medical professionals, school personnel, or parents, yet it affects an alarmingly high number of children around the world. A primary implication for practice and future research is to increase awareness and to continue to decrease stigma and fear about childhood suicidality. If the issue is not accepted as a worldwide public health crisis, it will never be addressed as one. The following paragraphs will describe implications for counselor educators, mental health counselors and school counselors encountering suicidal children, and researchers.

**Counselor Educators.** Counselor educators will be on the front line of teaching new counselors how to approach the topic of childhood suicidality, and can certainly infuse the findings of this research to inform their teaching. This should begin with a personal reflection on personal biases and thoughts about children and suicide, so that counselors-in-training confront possible discomfort about suicide and childhood suicide prior to encountering their first suicidal child in clinical practice. For programs accredited with The Council for the Accreditation of Counseling and Related Educational Programs (CACREP), specific coursework in addressing suicidality and crisis intervention is already required (CACREP, 11.5.g, 2009). However, counselor educators can ensure that the topic of suicide is presented as a lifespan issue, and include information on the specific characteristics, triggers, and treatment implications for

children 10 and younger. Counselor educators can also promote further research for childhood suicidality.

**Mental Health Counselors Encountering Suicidal Children.** Mental health counselors will be on a different front line of approaching the topic of childhood suicidality, as they will directly encounter suicidal children. Mental health counselors should familiarize themselves, their clients, and their clients' families and other treatment providers about the risk factors and warning signs of childhood suicidality, which are different from those of adolescents and adults. For example, this study will inform counselors that certain mental health diagnoses (ADHD, Adjustment Disorder, Mood Disorder, Oppositional Defiant Disorder, PTSD, and psychosis) are related to childhood suicidality. It is possible that a child who presents with ADHD, for example, will have an underlying suicidality, and mental health counselors will need to identify and distinguish the unique symptomatology.

Mental health counselors should become aware of what resources are available in their area for crisis screening, hospitalization, and children's psychiatry. Mental health counselors should consult with their clinical and administrative supervisors regarding policies and protocol for responding to suicidality. Collaborating with other members of a treatment "team" – even informally – will be essential in providing sufficient supervision and care across settings. Mental health counselors should also familiarize themselves with the laws in their state, such as mandated reporter laws. Mental health counselors encountering suicidal children can utilize The RESCUE Model for Childhood Suicidality to remember the important steps in responding to and beginning to treat

suicidal children 10 and younger. They should recall that each child is unique and will require an individualized treatment plan to meet their needs.

**School Counselors Encountering Suicidal Children.** School counselors will also encounter suicidal children, and often identify suicidality for the first time. For this reason, they should take similar steps as mental health counselors to prepare to recognize suicidality in children 10 and younger. School counselors can also utilize The RESCUE Model for Childhood Suicidality when encountering suicidal children 10 and younger, and should also know that prevention and intervention programs already exist for kindergarten through high school students and teachers. For example, Zenere and Lazarus (2009) tested such a curriculum in the Miami-Dade County Public Schools of Florida, and saw a tremendous decrease of youth suicidality over the course of a 17-year period. School-based prevention and intervention strategies can reach a large audience of children and provide education and possibly reduce stigma and myths about childhood suicidality for other school personnel.

**Researchers.** There is a great deal of research to be done on the topic of childhood suicidality, which is separate from adolescent and adult suicidality. The first way in which this study can affect future research is to encourage a more accurate definition of terms when referring to children, youth, adolescents, and the like. Next, this study was limited to children 3 years of age and older by the source of treatment charts for the content analysis, which included only children preschool-aged and above. Children 0 to 2 were not included in the content analysis, and only once referred to by a treatment provider. As this study found that suicidality might also affect infants, additional research needs to focus on the full range of children from 0 to 10. Then, an

assessment tool can be created and tested in clinical trials for its usefulness in the assessment and diagnosis of childhood suicidality.

In addition, several of the codes identified in this study required additional research, including research on: urination in inappropriate places or enuresis, stealing or theft, physical health diagnoses (such as asthma, allergies, and frequent ear infections or ear tubes), and specific interventions for childhood suicidality (such as CBT and TF-CBT). Clinical trials are required to evaluate the effectiveness of The RESCUE Model for Childhood Suicidality and each of its steps: Rescue, Evaluate, Safety, Collaborate, Understand, and Engage. Future research will also be needed to distinguish this model as a unique treatment intervention for suicidal children, as compared to suicidal adolescents and adults. In addition, it will be important to evaluate if The RESCUE Model for Childhood Suicidality is a tool that might reduce counselor anxiety about encountering suicidal children, and therefore reduce one barrier to effective treatment. Treatment provider discomfort can also be researched separately to identify what factors regarding childhood suicidality produce the sense of inexperience.

Finally, evidence of children's protective factors and strengths were not identified through this study, despite the open-ended nature of questions asked of the treatment providers. For example, Question 4 of the Interview Protocol (see Appendix A-4) asked, "What do you think is most important for people to know about suicidality in children?" Similarly open-ended, Question 5 inquired, "Is there anything I have not asked that you think would help me to better understand childhood suicidality?" Only one participant (P010) discussed hopefulness for the outcomes of suicidal children. He stated, "I think a lot of our kids if they get the right help, it can be uh hopeful. I mean, obviously, there's

going to be scars and stuff for a lifetime, but hopefully that they can live a lifetime!”

P001 stated that he had observed a 9-month remission of suicidal symptomatology after 5 years of severe suicidal behaviors and multiple attempted suicides. However, he did not describe exactly what factors led to this remission. It remains unknown which protective factors and strengths would be most important to promote for suicidal children.

Therefore, additional research should focus on the positive qualities of suicidal children and their potential for a remission of symptomatology.

### **Limitations**

Limitations for this study included researcher bias and a smaller sample size. This researcher has many years of experience serving suicidal children and would have also qualified as a potential participant in this study, as she met the educational, experience, and training requirements. She came into this research with pre-existing ideas and feelings on the topic of childhood suicidality, which she bracketed prior to and throughout the research project through the use of memoing and debriefing with the research team. This researcher, who also served as the interviewer, had knowledge of several of the suicidal children that were discussed in the interviews and of the resources to which the treatment providers referred. Many of the researcher’s personal experiences with local resources were negative, which led the researcher to further investigate treatment for suicidal children.

The sample size of this study, which included 12 treatment providers, was relatively small. According to Creswell (2007), a grounded theory methodology should include a sample size of approximately 20 to 60 individuals. When the data from the 12 interviews were triangulated with data from the 22 treatment charts of suicidal children, a

total of 34 voices were heard in this study. Unfortunately, the suicidal children's voices were not directly heard in this study. Also, children ages 0-2 were not included in the content analysis, due to the eligibility requirements for the counseling agency that accepted only children 3 and older. Another limitation is that all of the participants and suicidal children came from the same region of New Jersey, and no data sources came from other sites in the United States, which may limit the study's generalizability. The treatment providers were only interviewed once in this study, which may have impacted their willingness to disclose emotions and experiences regarding the sensitive topic of childhood suicidality. In addition, other types of treatment providers, such as medical doctors, teachers, psychologists, etc., were not included in this study, although these other professions likely encounter suicidal children on a regular basis. Additional research that includes these other types of providers is necessary to better understand the topic from multiple perspectives.

### **Difficulties**

This researcher found it quite challenging to recruit treatment providers to participate in interviews. As mentioned in Chapter 3, a total of 8 treatment providers who were eligible for the study declined their participation either verbally or in writing, and stated that they did not have the required experience with suicidal children. Many more treatment providers simply did not respond to the request for participants. This might be related to the barriers to treatment subtheme, "treatment provider feels inexperienced." It may be that treatment providers feel uncomfortable discussing childhood suicidality or suicidality in general, or uncomfortable being referred to as an experienced treatment provider. As all of the participants in the study indicated, they did

not feel as though they were experts on the subject of childhood suicidality, although many of them had 10 or more years of experience serving the population.

## **Conclusion**

The findings of this study provide a comprehensive view of childhood suicidality in children 10 and younger, that is clearly distinct from adolescent and adult suicidality. The results challenge long-standing misconceptions and myths that children cannot be suicidal, cannot engage in intentionally suicidal behaviors, and cannot attempt or complete suicide. This study has identified factors that influence childhood suicidality, confirming previous research studies that suggest triggers of abuse, neglect, trauma, separation from a primary caregiver, and a family history of suicidality. At the same time, the study presents new factors to explore in future research, such as a family history of mental illness and substance abuse, and parenting concerns or involvement with DCP&P. This study introduces The RESCUE Model for Childhood Suicidality to help guide treatment providers and other adults in navigating a response to and interventions for suicidal children 10 and younger. The study confirms past research on crisis screening, psychiatric hospitalization, and psychotropic medication, which highlights skepticism and appropriateness of these interventions for children. Finally, the study discusses barriers to effective treatment for childhood suicidality, which might be helpful to treatment providers, as they may feel particularly challenged by working through the complexities of suicidal children. While there were some limitations and challenges with this study, the results remain valuable to counselor education, the counseling field, and research regarding childhood suicidality.

## CHAPTER SIX

## MANUSCRIPT

## A Grounded Theory of Suicidality in Children Ten and Younger

Katherine A. Heimsch and Danica G. Hays

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### Abstract

Although a child aged 5 to 14 years old dies by suicide approximately once every two days in the United States, (World Health Organization [WHO], 2010), children ages 10 and younger have not been researched separately from adolescents and adults. Data in this grounded theory were derived from 12 semi-structured interviews with treatment providers and a content analysis of 22 treatment charts of suicidal children age 10 and younger. Findings indicate that childhood suicidality involves a range of behavioral and emotional disruption with several causal conditions (i.e., abuse and neglect, separation from a primary caregiver, negative familial influences, and mental and physical illness). Further, identified treatments include psychiatric interventions as well as a cluster of interventions conceptualized as The RESCUE Model for Childhood Suicidality.

### A Grounded Theory of Suicidality in Children Ten and Younger

Suicide is the tenth leading cause of death for all age groups in the United States, and the third leading cause of death for those 15-24 years old (CDC, 2012). In 2010 alone, the CDC (2012) recorded 38,364 total suicides in the United States, or approximately 105 deaths by suicide per day. Although much less discussed, suicide (and related behaviors and thoughts) can and does affect children ages 10 and younger.

Formal research on children's suicidality began as early as 1885 by Durand-Fardel, and was studied by master psychoanalysts such as Freud and Adler (Pfeffer, 1986); however, current research does not differentiate significantly between children and adolescents' suicidality, although there may be significant differences in presentation and needs (Ben-Yehuda, Aviram, Govezenski, Nitzan, Levkovitz, & Bloch, 2012). A recent search made on PsycINFO for the term *suicide* resulted in approximately 16,397 hits for articles, dissertations, and books over the past five years. Of those, 12,772 (about 78%) were written on adult age groups; 2,030 (about 12%) on adolescents; and only 1,595 (about 10%) on children. Although these figures appear to reasonably represent the world population of children and adolescents, an actual review of the literature shows that children are not at all well represented in articles – even in those with “child” or “children” in the title. Specifically, an age group of children 10 years and younger has not been adequately studied in the literature purportedly about suicidality.

The age at which children can comprehend the construct of suicide is a longstanding debate in professional literature (Davis, 2004; Dervic, Friedrich, Oquendo, Voracek, Friedrich, & Sonneck, 2006; McGlothlin, 2008; Mishara, 1999). While suicidality increases with age – especially in the adolescent years (WHO, 2010), there lacks an

explicitly stated lower age limit in the literature. Further, the WHO reports on deaths by suicide starting at age five, but other authors have indicated that suicidal behaviors have been observed in children as young as four (Skala, Kapusta, Schlafl, Unseld, Erfurth, Lesch, ...Akiskal, 2012), and that preschool-age children are able to understand the concept of death (Siegal, 2008). In addition, depression, or at least a depressive affect, has even been observed as early as infancy (Luby, 2009; Shamoo & Patros, 1997).

Every year in the United States, approximately five children age 9 years and younger die by suicide (a total of 57 from 1999 to 2010; CDC, 2013), and it is likely that dozens more go undetected or are labeled “accidents” (Mishara, 1999). When combined with the estimations that adolescents attempt suicide 50-100 times more frequently than they complete suicide (Cheng, Tao, Riley, Kann, Ye, Tian, ...& Hu, 2009), and 15-24 year olds attempt 100-200 times more frequently than they complete (CDC, 2012), the prevalence of childhood suicidality becomes a much greater concern when viewed as a lifespan issue. If the trends of adolescents are similarly congruent with those of younger children, the implication is that 250 to 1,000 children are likely to attempt suicide every year, thousands more will engage in suicidal behaviors or make plans to injure themselves, and tens of thousands may experience suicidal ideation. Davis (2004) stated, “Statistics indicate that the rate of suicide among children, even those under the age of 10, may be grossly underestimated” (p. 211).

### **Methodology**

The purpose of this grounded theory was to understand the phenomenon of suicidality, specific to those age 10 and younger with suicidality defined as a spectrum of ideations, verbalizations, behaviors, attempts, and completions. The following three

research questions were addressed: (1) What are the characteristics of suicidality in children 10 years and younger?; (2) What factors influence childhood suicidality?; and (3) What are the treatment implications for children 10 years of age and younger who present with suicidality? There exists some prevalence of literature on children's suicidality but is a lack of scholarship on *how* and *why* suicide affects this population to guide prevention and intervention efforts.

### **Research Team**

The primary researcher was a biracial (Caucasian/Hispanic) female doctoral student in counselor education, with an educational specialist degree in community counseling, and nine years of direct experience working as a mental health counselor for at-risk and suicidal youth. Due to the primary researcher's insider knowledge regarding suicidal children, several biases and assumptions about the population were identified prior to data collection. Most significantly, the primary researcher believed that myths about suicidal children were widespread – even amongst treatment providers – and felt that treatment interventions were sparse and not age-appropriate for children 10 and younger. To manage the influence of biases and assumptions on this study, the primary researcher utilized a research team, which included two additional doctoral students studying counselor education, and an external auditor. The second team member was a Caucasian female with a master's degree in counseling, cognate in qualitative research, and a shared research focus of suicidality. The third team member is an Asian female with a master's degree in counseling, experience with qualitative research, and specific work using grounded theory methodology. The research team was utilized to develop an interview protocol and a coding frame prior to data collection, and to analyze and

interpret data collected throughout the study. The external auditor was an advanced clinician, employed by the counseling agency, who monitored the primary researcher's involvement with the agency and its consumers, and ensured trustworthiness by reviewing the project for adherence to the procedures and accuracy in reporting.

After gaining IRB approval, the primary researcher met with the directors and ethics committee of a large, not-for-profit mental health counseling agency for children and families of a state located in the northeast United States, and obtained specific written permission to work with the data collected from consumers of their agency and to interview their employees. The agency employs approximately 1,400 employees and served more than 2,800 children in the year 2013 alone, all of whom had been diagnosed with at least one mental health diagnosis in accordance with the *DSM-IV-TR* (American Psychiatric Association, 2000). Data collection included two main components: individual interviews of treatment providers who have had experience working with suicidal children, and a content analysis of closed treatment charts for children 10 and younger who had presented with suicidality either before or during treatment.

Participants for the qualitative interviews in this study were recruited through snowball sampling (Hays & Singh, 2012), beginning with mental health counselors who were employees of the agency and extending to several others who were recommended by the agency staff. The primary researcher assumed that all of these treatment providers were experts on suicidal clients and that they could provide interpretation of therapeutic experiences to the primary researcher. The expertise was determined through a brief screening questionnaire, that assessed individuals' educational and practice backgrounds. Selected participants held a master's degree or higher in counseling or a closely related

field (i.e., psychiatry, social work), had at least one year of combined treatment experience with one or more suicidal children aged 10 or younger, and had completed specific training in suicidality through either an academic course or professional continuing education.

Approximately 92 eligibility questionnaires were distributed to employees of the counseling agency and to those who had specifically been referred as potential participants (several of whom also worked at other counseling agencies or schools). The primary researcher received 24 completed eligibility questionnaires, including those of the final 12 eligible and interested participants, as well as 9 individuals who did not meet eligibility requirements, and 3 individuals who were eligible but not interested in participating in counseling research. Five additional individuals declined participation verbally or through email. The final cohort of participants included nine mental health counselors from the counseling agency, one mental health counselor employed by another agency, one child psychiatrist, and two school counselors.

### **Interviews**

The primary researcher conducted and video recorded 12 semi-structured interviews of approximately one hour in length. The interview protocol included the following questions: (1) Tell me about your experiences with children's suicidality in your caseload/practice. (2) How have you first recognized that a child in your caseload/practice was suicidal? (3) What do you think are the most important interventions and modalities, if any, for suicidal children? (4) What do you think is most important for people to know about suicidality in children? (5) Is there anything I have not asked that you think would help me to better understand childhood suicidality?

Additional follow-up questions were asked in order to reflect and ensure understanding of the content provided by the treatment providers.

### **Treatment Charts**

The primary researcher requested from the treatment staff of the counseling agency treatment charts of children 10 and younger who had previously been identified as suicidal regardless of comorbidity or specific diagnoses; 22 closed charts were retrieved from the on-site medical records storage facility at the agency. A staff member of the agency copied the charts and masked all identifying information to maintain the children's confidentiality. Charts contained documentation regarding the suicidal children's psychiatric, social-emotional, educational, medical, and developmental histories.

### **Data Analysis**

As interview data were collected, the primary researcher transcribed each recording, and shared a hard copy of the transcript with the treatment provider for member checking. None of the 12 participants wished to revise, retract, or add statements to their original interviews. The primary researcher then composed a contact summary sheet (Miles & Huberman, 1994), to highlight initial reflections on interview data. The primary researcher engaged in simultaneous data collection and analysis (Charmaz, 2014). Four rounds of coding were used in the data analysis. Rounds one and two employed substantive coding (Holton, 2007), which focused on identifying new information and themes related to children's suicidality. Rounds three and four focused on theoretical coding, comparing themes until saturation was met and a theory could be created. For the first six interviews, the primary researcher independently engaged in

three rounds of open coding and created a codebook after every two interviews. After completing this process, the primary researcher created a master codebook and shared this with the research team. The research team then independently and consensus coded interviews seven through twelve, stopping after every two interviews to meet and discuss the coding and theory creation process.

A parallel process occurred between data analysis for the interview data and data analysis for the treatment chart data. The primary researcher reviewed clients' treatment charts, transcribed the data using a standardized data collection tool, and shared these transcriptions with the research team in order to complete a summative content analysis (Hsieh & Shannon, 2005). This process began with frequency counting of particular keywords or content as it related to the research questions. After the research team agreed upon the codes, the primary researcher followed with a round of interpretation to relate the data to answer the research questions. Data derived from this content analysis were triangulated with data derived from the individual interviews. Together, these data were included in a final codebook for informing grounded theory development.

### **Trustworthiness**

The primary researcher included several strategies for trustworthiness to improve the rigor and quality of the research that addressed four qualitative criteria of trustworthiness (i.e., credibility, transferability, dependability, and confirmability). Strategies included an audit trail, simultaneous data collection and analysis, triangulation of data sources, methods, and investigators, member checking, and thick description

## **Findings**

The findings of this study identified characteristics, causal conditions, and treatment implications of childhood suicidality that were specific to children 10 years and younger. The model depicted in Figure 1 shows the relationship between these factors. More specifically, this figure represents the theoretical and axial codes that were determined by this research to interpret the phenomenon of childhood suicidality. The most prominent feature of this model is the core category of childhood suicidality, which represents the full spectrum of suicidality (ideations, verbalizations, behaviors, attempts, and completions). Childhood suicidality was shown to be affected by six causal conditions: abuse & neglect, separation from a primary caregiver, other traumas & stressors, negative familial influences, mental illness, and physical illness. The arrows moving away from the construct of childhood suicidality depict how treatment providers are required to make choices regarding the appropriate treatments and interventions for childhood suicidality. Two categories of interventions were found to be the most widely used and recommended: psychiatric interventions (i.e., crisis screening, psychiatric hospitalizations, and psychotropic medications) and a proposed RESCUE Model for Childhood Suicidality. Finally, several barriers to treatment moderate the effectiveness of treatment interventions and serve as an additional causal condition in the theoretical model.

### **Childhood Suicidality**

Four axial codes identified the presence of suicidal ideation, suicidal verbalizations, suicidal behaviors, and suicide attempts among children, despite their possible limitations in understanding the meaning and finality of death. Table 1 provides

supportive quotes from interview and treatment chart data for these codes. *Suicidal ideation* affected 86.36% ( $n = 19$ ) of children whose treatment charts were reviewed, and 100% of the treatment providers interviewed reported that they had encountered suicidal ideation among the children they served. Two treatment providers reported that suicidal ideation was more prevalent (they each estimated around 50%) among children who had been separated from a primary caregiver. *Suicidal verbalizations* were present in 90.19% ( $n = 20$ ) of children's treatment charts, and 100% of the treatment providers interviewed reported that they had encountered suicidal verbalizations among the children they served. Exact statements related to suicide varied greatly, as some children made very direct statements about wanting to die, while other children made comments that were more vague. Some children verbalized specific actions that they would take to end their lives, which may have been feasible for the child to act upon, while other statements were more outlandish. Suicidal verbalizations were often reported during tantrums or when the child felt angry or upset, and one chart in particular explained how a child recanted his suicidal statement when he was feeling calmer.

The third axial code, *suicidal behaviors*, was present in 86.36% ( $n = 19$ ) of children's treatment charts, and 100% of the treatment providers interviewed reported that they had encountered suicidal behaviors among the children they served. Exact suicidal behaviors varied greatly. Some children made suicidal gestures, such as putting a knife to their throat, or putting a belt around their neck. Others engaged in risky behaviors, such as running out into a street or parking lot. Still others engaged in deliberate self-harming behaviors, in varying degrees of lethality, such as: biting oneself, head banging, and vaginal mutilation.

Finally, *suicide attempts* were present in 31.82% ( $n = 7$ ) of children's treatment charts, which indicates that suicide attempts were the least frequently occurring form of suicidality in this sample. Suicide attempts ranged in number from 1 to 6 attempts, as defined by the authors of the treatment charts. Ten treatment providers (83.33%) interviewed had encountered suicidal attempts by the children that they served. In addition, suicide completions were also discussed in one interview with a treatment provider. Although rare, completed suicides in children 10 and younger were confirmed through this study, particularly among children who are chronically physically ill.

Thus, children who are suicidal may display a wide variety of behaviors and emotions, as evidenced by the 52 unique characteristics found in children's treatment charts. Sixteen observable qualities, described both by the treatment providers and children's treatment charts, were frequently present in suicidal children, and may be considered warning signs for childhood suicidality (See Table 2).

### **Causal Conditions**

There were 6 axial codes that represented the most frequent causal conditions of childhood suicidality, including: abuse (including emotional, physical, and sexual) and neglect, separation from a primary caregiver, other trauma & stressors, negative familial influences, mental illness, and physical illness. In addition, five barriers to effectively treating suicidal children were found to be common: difficulty in accurately assessing childhood suicidality; lack of an assessment tool to assist in diagnosing suicidal children; feeling inexperienced or unprepared to manage suicidal children; encountering myths about suicide in children; and finding parents to be a frequent barrier to treatment. Table 1 provides supporting documentation for these conditions.

## Treatment for Childhood Suicidality

Many treatment interventions have been used to treat suicidal children (See Table 1). Psychiatric interventions, including crisis screening, psychiatric hospitalization, and psychotropic medication, were among the most frequently used interventions, and treatment providers discussed benefits and limitations to all three types. In addition, data were found to support the creation of The RESCUE Model for Childhood Suicidality, which can be used as a guide for treatment providers encountering suicidal children 10 and younger. For “The RESCUE Model,” researchers found that the wide range of interventions could be grouped in order of six steps that could be utilized by treatment providers. These steps were organized by the research team into the acronym, R.E.S.C.U.E.

**Respond (R).** The *Respond* theme describes how an adult can best respond to a child who demonstrates suicidality. First, the adult should take all warning signs, verbalizations, threats, or behaviors of childhood suicidality seriously. In addition, several treatment providers highlighted the importance of remaining calm and responding with compassion and empathy to the suicidal child because it is likely that they are experiencing deep emotional pain. The last step of the Respond theme is to begin to act immediately to help a suicidal child.

**Evaluate (E).** The *Evaluate* theme describes ways in which the adult responder can gather additional information about the suicidal child in order to weigh the seriousness of the situation and later know which resources to utilize. After an adult observes a behavior change in a child, the next step is to ask probing questions to understand their situation and learn more about their suicidality. Asking questions also

requires that the adult be patient and listen to the child's full answers. The most important part of the evaluation step is to assess potential risks for the child and those around them, including both physical and emotional consequences.

**Safety (S).** The *Safety* theme describes ways to ensure safety across settings. All treatment providers interviewed discussed safety as an essential goal. Treatment providers need to ensure that increased adult supervision is available to the children, access to lethal means is limited, and that individualized safety plans are designed and implemented.

**Collaborate (C).** The *Collaborate* theme emphasizes the importance of having a collaborative team when treating suicidal children. The child's parents or caregivers are obviously a very important part of the collaborative team, but they may need specific education about childhood suicidality. Other treatment providers, such as mental health and school counselors, primary care physicians, school nurses, psychiatrists, etc., should also be utilized. Counselors at any developmental level should consult their clinical supervisor or another treatment provider who is experienced in childhood suicidality.

**Understand (U).** The *Understand* theme encompasses several interventions for addressing suicidal children's emotions and offering support. This label reminds adults to consider the child's feelings and to acknowledge that those feelings are real to the child, no matter how trivial they may seem to adults. One of the most frequent codes under this theme was to help the suicidal child to "find a trusted adult." In addition, many relaxation techniques were suggested in this step in both the interviews and the treatment charts.

**Engage (E).** The *Engage* theme marks the last step when encountering a suicidal child and the initial steps to take to begin the therapeutic work. The treatment charts showed that 90.91% ( $n = 20$ ) of suicidal children in this study had also received individual counseling in either an outpatient ( $n = 18$ ) or in-home ( $n = 2$ ) setting. The theoretical orientation of treatment providers who offered counseling to the children was rarely reported in the treatment charts. However, a few modalities were noted. For example, Cognitive Behavioral Therapy (CBT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) were listed. Several treatment providers also discussed modalities of therapeutic interventions, which included, for instance, the use of sand tray and puppets; journaling; psychoeducation for the child; play therapy; and art, drama, music, movement, and the use of metaphor. Therefore, many therapeutic interventions may be useful to treat suicidal children. It is important to keep in mind their individual triggers of suicidality and to work towards treating the root cause and not just the symptomatology.

### **Discussion**

The findings of this study provide a theoretical model of childhood suicidality in children 10 and younger. The results challenge long-standing misconceptions and myths that younger children cannot be suicidal, cannot engage in intentionally suicidal behaviors, and cannot attempt or complete suicide. The researchers have identified factors that influence childhood suicidality, confirming previous research studies that suggest triggers of abuse, neglect, trauma, separation from a primary caregiver, and a family history of suicidality (Hawton & Harriss, 2008; O'Connell, 2012; Rajalin, Hirvikoski, & Jokinen, 2012; Riesch, Jacobson, Sawdey, Anderson, & Henriques, 2008;

Rhodes et al., 2012; Zapata et al., 2012). At the same time, the study presents new factors to explore in future research, such as a family history of mental illness and substance abuse, and parenting concerns or involvement with state social service agencies. The RESCUE Model is proposed to help guide treatment providers and other adults in navigating a response to and interventions for childhood suicidality. The researchers support past research on crisis screening, psychiatric hospitalization, and psychotropic medication (Flannery, 2006; Horowitz, et al., 2001; Pompili, Mancinelli, Giardi, Ruberto, & Tatarelli, 2004), which highlights skepticism and appropriateness of these interventions for children 10 and younger. Finally, barriers to effective treatment for childhood suicidality, which might be helpful to mental health counselors, are presented.

There are several limitations to this study. The sample size, which included 12 treatment providers, was relatively small. According to Creswell (2013), a grounded theory methodology should include a sample size of approximately 20 to 60 individuals. Although data from 22 treatment charts helped to triangulate the data and support sampling adequacy, voices of the children themselves were not directly heard. The treatment providers only included mental health counselors, school counselors, and a child psychiatrist. Other treatment providers who may regularly encounter suicidal children, such as primary care physicians, were not included, except through minimal documentation in the treatment charts. In addition, the treatment providers were only interviewed once, and may not have felt a strong rapport with the primary researcher to feel comfortable discussing the sensitive subject of childhood suicidality.

Another limitation is that all of the participants and suicidal children came from the same region of one northeast U.S. state. Although there was racial diversity in the treatment chart sample (45% Caucasian, 41% African American, 9% multiracial, 5% Hispanic), the sample lacked diversity in terms of socioeconomic status (95% were of low socioeconomic status). In addition, this study was limited to children 3 years of age and older by the source of treatment charts for the content analysis, which included only children preschool-aged and above. Children 0 to 2 were not included in the content analysis, and only once referred to by a treatment provider. As this study found that suicidality might also affect infants, additional research needs to focus on the full range of children from 0 to 10.

### **Implications for Practice**

Mental health counselors are on the front line of approaching the topic of childhood suicidality, as they will directly encounter suicidal children. Thus, they should familiarize themselves, their clients and their clients' families, and other treatment providers about the risk factors and warning signs of childhood suicidality. For example, this study can inform counselors that certain mental health diagnoses are related to suicidality. Mental health counselors should become aware of what resources are available in their area for crisis screening, hospitalization, and children's psychiatry. Mental health counselors should consult with their clinical and administrative supervisors regarding policies and protocol for responding to suicidality. They should also familiarize themselves with the laws in their state, such as mandated reporting laws. Mental health counselors encountering suicidal children can utilize The RESCUE Model to remember the important steps in responding to and providing treatment for suicidal

children. They should also recall that each child is unique and will require an individualized treatment plan. Collaborating with other members of a treatment “team” – even informally – will be essential in providing sufficient supervision and care across settings.

### **Implications for Future Research**

There is a great deal of research still to be done on the topic of childhood suicidality, which is separate from adolescent and adult suicidality. The first way in which this study can affect future research is to encourage a more accurate definition of terms when referring to children, youth, and adolescents. In addition, this discussion noted that several of the codes identified in this study required additional research, including research on: urination in inappropriate places or enuresis, stealing or theft, physical health diagnoses (such as asthma, allergies, and frequent ear infections or ear tubes), and specific interventions for childhood suicidality (such as CBT and TF-CBT).

Finally, evidence of children’s protective factors and strengths were not identified through this study, despite the open-ended nature of questions asked of the treatment providers. Only one participant (P010) discussed hopefulness for the outcomes of suicidal children. He stated, “I think a lot of our kids if they get the right help, it can be uh hopeful. I mean, obviously, there’s going to be scars and stuff for a lifetime, but hopefully that they can live a lifetime!” P001 stated that he had observed a 9-month remission of suicidal symptomatology after 5 years of severe suicidal behaviors and multiple attempted suicides. However, he did not describe exactly what factors led to this remission. It remains unknown which protective factors and strengths would be most important to promote for suicidal children. Therefore, additional research should focus

on the positive qualities of suicidal children and their potential for a remission of symptomatology.

## Article References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, Author.

Ben-Yehuda, A., Aviram, S., Govezenski, J., Nitzan, U., Levkovitz, Y., & Bloch, Y. (2012). Suicidal behavior in minors – Diagnostic differences between children and adolescents. *Journal of Developmental & Behavioral Pediatrics*, 33, 542-547. doi: 10.1097/01.DBP.0000415830.85996.e6

Centers for Disease Control and Prevention. (2012). *Suicide: Facts at a glance* [Fact sheet]. Author. Retrieved from <http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf>

Centers for Disease Control and Prevention. (2013). Fatal injury reports, National and regional, 1999 – 2010. Retrieved from [http://www.cdc.gov/injury/wisqars/fatal\\_injury\\_reports.html](http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html)

Charmaz, K. (2014). *Introducing qualitative methods: Constructing grounded theory*, Second Edition. Los Angeles, CA: Sage.

Cheng, Y., Tao, M., Riley, L., Kann, L., Ye, L., Tian, X., . . . Hu, J. (2009). Protective factors relating to decreased risks of adolescent suicidal behaviour. *Child: Care, Health and Development*, 35, 313-322. doi:10.1111/j.1365-2214.2009.00955.x

Creswell, J. W. (2013) *Qualitative inquiry and research design: Choosing among five approaches* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage.

Davis, T. (2004). Counseling Suicidal Children. In D. Capuzzi (Ed.), *Suicide across the lifespan: Implications for counselors* (pp. 211-234). Alexandria, VA: American Counseling Association.

- Dervic, K., Friedrich, E., Oquendo, M. A., Voracek, M., Friedrich, M. H., & Sonneck, G. (2006). Suicide in Austrian children and young adolescents aged 14 and younger. *European Child & Adolescent Psychiatry, 15*, 427-434. doi:10.1007/s00787-006-0551-6
- Flannery, D. J. (2006). *Violence Prevention and Policy Series: Violence and mental health in everyday life: Prevention and intervention strategies for children and adolescents*. New York, NY: AltaMira Press.
- Hawton, K., Bergen, H., Kapur, N., Cooper, J., Steeg, S., Ness, J., & Waters, K. (2012). Repetition of self-harm and suicide following self-harm in children and adolescents: Findings from the Multicentre Study of Self-Harm in England. *Journal of Child Psychology and Psychiatry, 53*, 1212-1219. doi: 10.1111/j.1469-7610.2012.02559.x
- Hays, D. G. & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. New York, NY: Guilford Press.
- Hepp, U., Stulz, N., Unger-Köppel, J., & Ajdacic-Gross, V. (2012). Methods of suicide used by children and adolescents. *European Child & Adolescent Psychiatry, 21*, 67-73. doi: 10.1007/s00787-011-0232-y
- Holton, J. A. (2007). [The Coding Process and Its Challenges]. In A. Bryant and K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 265-289). Thousand Oaks, CA: Sage.
- Horowitz, L. M., Wang, P. S., Koocher, G. P., Burr, B. H., Smith, M. F., Klavon, S., & Cleary, P. D. (2001). Detecting suicide risk in a pediatric emergency department: Development of a brief screening tool. *Pediatrics, 107*, 1133-1137.

- Hsieh, H-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*, 1277-1288. doi: 10.1177/1049732305276687
- Klonsky, E. D., & Olino, T. M. (2008). Identifying clinically distinct subgroups of self-injurers among young adults: A latent class analysis. *Journal of Consulting and Clinical Psychology, 76*, 22-27. doi: 10.1037/0022-006X.76.1.22
- Luby, J. L. (2009). Depression. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (3rd ed., pp. 409-420). New York, NY: Guilford Press.
- McGlothlin, J. M. (2008). *Developing clinical skills in suicide assessment, prevention, and treatment*. Alexandria, VA: American Counseling Association.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Mishara, B. L. (1999). Conceptions of death and suicide in children ages 6-12 and their implications for suicide prevention. *Suicide and Life-Threatening Behavior, 29*, 105-118. doi: 0.1111/j.1943-278X.1999.tb01049.x
- O'Connell, K. L. (2012). Child and Adolescent Suicide. *Journal of Child and Adolescent Psychiatric Nursing, 25*, 111-112. doi: 10.1111/j.1744-6171.2012.00333.x
- Pfeffer, C. A. (1986). *The suicidal child*. New York, NY: Guilford.
- Pompili, M., Mancinelli, I, Girardi, P., Ruberto, A., & Tatarelli, R. (2005). Childhood suicide: A major issue in pediatric health care. *Issues in Comprehensive Pediatric Nursing, 28*, 63-68.
- Rajalin, M., Hirvikoski, T., & Jokinen, J. (2012). Family history of suicide and exposure to interpersonal violence in childhood predict suicide in male suicide attempters.

*Journal of Affective Disorders*, no pagination specified.

doi:10.1016/j.jad.2012.11.055

Rhodes, A. E., Boyle, M. H., Bethell, J., Wekerle, C., Goodman, D., Tonmyr, L., ...

Manion, I. (2012). Child maltreatment and onset of emergency department presentations for suicide-related behaviors. *Child Abuse & Neglect*, 36, 542-551.

doi:10.1016/j.chiabu.2012.04.006

Riesch, S. K., Jacobson, G., Sawdey, L., Anderson, J., & Henriques, J. (2008). Suicide ideation among later elementary school-aged youth. *Journal of Psychiatric and Mental Health Nursing*, 15, 263-277. doi: 10.1111/j.1365-2850.2007.01221.x

Shamoo, T. K., & Patros, P. G. (1997). *The Jossey-Bass Psychology Series: Helping your child cope with depression and suicidal thoughts*. San Francisco, CA: Jossey-Bass. (Original work published 1990: "I want to kill myself" Lexington, MA: Lexington Books.)

Siegal, M. (2008). Life and death. In *Marvelous minds: The discovery of what children know* (pp. 99-115). New York, NY: Oxford University Press.

Skala, K., Kapusta, N. D., Schlaff, G., Unseld, M., Erfurth, A., Lesch, O., ... Akiskal, H. S. (2012). Suicidal ideation and temperament: An investigation among college students. *Journal of Affective Disorders*, 141, 399-405. doi: 10.1016/j.jad.2012.03.010

Skinner, R., & McFaull, S. (2012). Suicide among children and adolescents in Canada: Trends and sex differences, 1980-2008. *Canadian Medical Association Journal*, 184, 1029-1034. doi: 10.1503/cmaj.111867

World Health Organization. (2010). Suicide prevention. In *Distribution of suicide rates (per 100,000) by gender and age, 2005* [Fact sheet]. Retrieved from [http://www.who.int/mental\\_health/media/unitstates.pdf](http://www.who.int/mental_health/media/unitstates.pdf)

Zapata, L. B., Kissin, D. M., Bogoliubova, O., Yorick, R. V., Kraft, J. M., Jamieson, D. J., ... Hillis, S. D. (2013). Orphaned and abused youth are vulnerable to pregnancy and suicide risk. *Child Abuse & Neglect*, no pagination specified. doi: 10.1016/j.chiabu.2012.10.005

Figure 1.

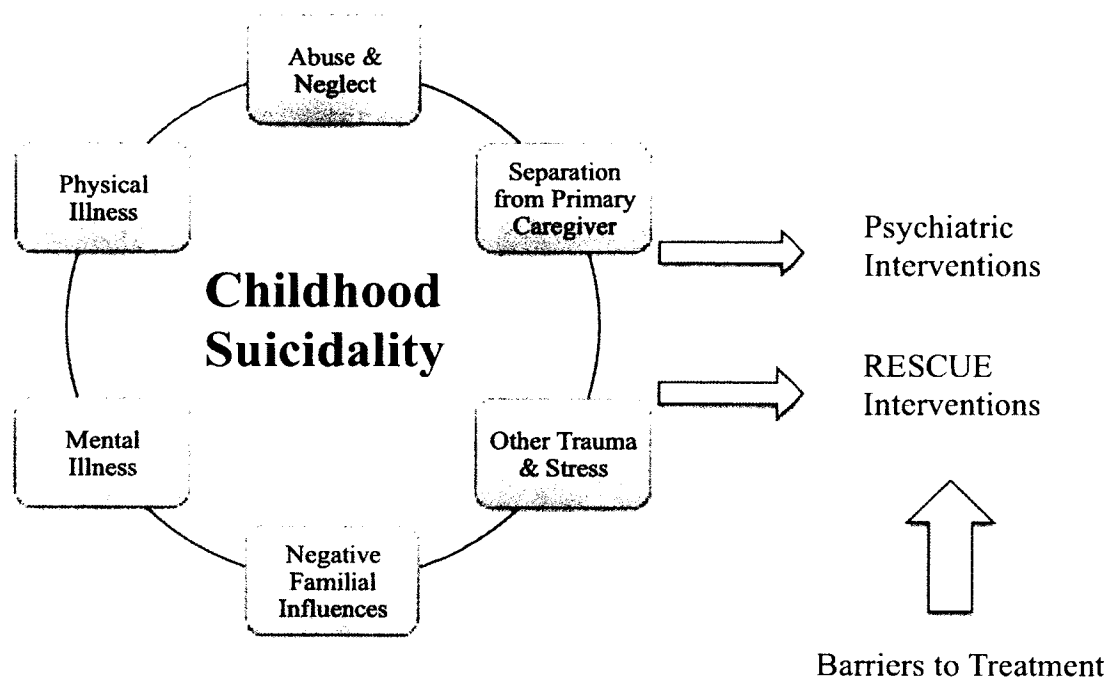
*A Model of Childhood Suicidality*

Table 1.

*Supportive Documentation for Core Category, Causal Conditions, and Treatment Implications.*

Finding	Supportive Statements
Suicidal ideation	<p>Evidence of suicidal thoughts without specific threats of suicide:</p> <p>“I can’t wait until I die.” (C001)</p> <p>“I’m trash.” (C004)</p> <p>“I hate myself, I’m stupid, I’m a loser” (C006)</p> <p>“I am evil, I am going to the devil- I am never going to see God” (C008)</p> <p>Play themes that are aggressive, violent, or focused on death. (C015, C016)</p>
Suicidal verbalization	<p>Specific statements with intent to die or significantly self-injure:</p> <p>“I want to die.” (C007)</p> <p>“I want to kill myself.” (C006)</p> <p>“I wish I wasn’t born.” (C009)</p> <p>“I don’t want to be here anymore.” (C017)</p> <p>“I want to starve.” (C020)</p> <p>Verbalized plans for suicidal behaviors:</p> <p>Jumping off a banister, setting skin on fire, or jumping off roof. (C016)</p> <p>“Get a cop’s gun and shoot myself.” (C001)</p> <p>“...But in that moment he was so distressed, we just needed- he needed to have that hurt go away somehow. And he repeated more than once that he wanted to kill himself. But he was four. And that was the first time I had ever heard a 1- a child that age- a pre-K, I mean, say that he wanted to die.” (P009)</p>
Suicidal behaviors	<p>Suicidal gestures:</p> <p>Putting a knife to their throat. (C001, C009, C018, C019)</p> <p>Putting a belt around their neck. (C003, C019)</p> <p>Risky behaviors:</p> <p>Running out into a street or parking lot. (C003, C004)</p> <p>Deliberate self-harming behaviors:</p> <p>Biting oneself. (C002, C003, C005, C006, C010, C016, C017, C021)</p> <p>Head banging. (C001, C006, C007, C010, C011)</p> <p>Vaginal mutilation. (C012)</p>

	Intentionally poor self-care. (P005, P006, P008, P009, P011)
Suicidal attempts	"This one eight year old boy, yknow, stuck his head in an oven and tried to turn it on and when that wasn't working, he put his head in a microwave and tried to turn that on." (P002)
Suicide completions	"It was really uhm children that were chronically ill that then didn't take their medication and ended up being hospitalized. Like, it was like they had a loaded gun. ...[Diabetic children] don't have to do anything more than eat a ton of sugar, not take their insulin, uhm- it's giving them permission to do what they have to do, knowing why they're doing it. ...And they purposely yknow, would change the medication around so as they would die. Yknow, or make the attempt." (P006)
Abuse & Neglect	<p><b>Physical abuse:</b> "Another example is a 9 year old boy was locked in a cage by his father uhm and just yknow beaten and things like that...So, it always seems to be very very at the extreme end of abuse uhm, in all of these children." (P002)</p> <p><b>Sexual abuse</b> (C002, C003, C008, C010, C012, C017, C018)  <b>Emotional or verbal abuse</b> (C007, C011, C013, C015, C018, C020)</p> <p><b>Neglect:</b> C003, a Caucasian female, had a substantiated history of neglect from age 2 to 3. She had been exposed to drug use and paraphernalia by her mother, the home had no heat or hot water, and the child was found by neighbors to be naked and wandering the neighborhood alone. The child was removed from her mother's care, and subsequent visits resulted in the child coming home dirty and inappropriately dressed for the weather.</p>
Separation from Primary Caregiver	<p>"Separation. Multiple separations. Uhm. (Takes a breath; Pauses.) Multiple separations I think almost at the top of the list." (P006)</p> <p>C014, a 3.5 year old whose father was incarcerated, had been in 5 foster homes within a few months due to his "out of control" behaviors.</p> <p>C003, a 5-year-old male who presented with frequent suicidal verbalizations and behaviors, had been placed in at least 4 different foster homes prior to his 5<sup>th</sup> birthday, including 3 homes in a 6-month period.</p>

<p>Other Trauma &amp; Stress</p>	<p>“Poverty. Definitely poverty. ...And you know when you walk in the home if there’s poverty, there’s a lack of resources, and to really call upon- a lack of supports in the family that they can really say, this is someone you can really trust and lean on.” (P006)</p> <p>“Have they recently experienced a loss, a death, a suicide in the family? Yknow, are they trying to reconnect with a person they’ve lost?” (P004)</p> <p>Verbal and/or physical bullying by peers (C009, C017, C018, C019)</p> <p>Self-blaming for life circumstances (C010, C011) Students classified for special education</p> <p>History of school detention(s) and/or suspension(s)</p> <p>Multiple minority statuses</p>
<p>Negative Familial Influences</p>	<p><b>Family dysfunction:</b> “I think in the younger kids, a lot of time, it’s more the family dynamic. If you’re looking at it from like a social perspective. So, yknow, are the parents together? Are they divorced? Is there violence in the house? Uhm...what kind of relationship- like attachment- do they have with the parent and/or caregivers? Uhm...are they in like a hopeless kind of situation? Yknow, are they in foster care and they feel like they don’t have anybody?” (P004)</p> <p><i>Also, Domestic violence:</i> “I would think that uh, witnessing domestic violence is certainly a big risk factor for children because once they feel unsafe with the adults around them, time and time again I’ve noticed that children that have just those really severe escalating behaviors, it’s because they see the adults that are supposed to be there caring for them, unable to care for them. And some children really cannot handle that.” (P008)</p> <p><b>Family history of mental illness:</b> “Or, yknow they obviously have their own – not obviously – but some of them also have their own trauma to deal with and are not in an emotionally well place to be able to handle their own children’s problems.” (P002)</p> <p><i>Family diagnoses included: ADHD, anxiety, Autism, Bipolar Disorder, Borderline Personality Disorder, depression</i></p>

	<p><i>(including postpartum depression), Dissociative Identity Disorder, PTSD, Schizoaffective Disorder, and Schizophrenia.</i></p> <p><b>Family history of substance abuse</b>  <i>Substances used by parents and other relatives of the suicidal children in this study included: alcohol, cocaine, crack cocaine, heroin (used intravenously), methamphetamine, opiates, as well as combinations of these drugs.</i></p> <p><b>Family history of suicidality:</b> “slit wrists in front of [child’s] younger brother, tried to hang himself a few times, and uses drugs.” (C019)</p> <p><b>Parenting concerns or involvement with DCP&amp;P</b></p>
Mental Illness	<p>Most frequent diagnoses: ADHD, Mood Disorders, Adjustment Disorder, PTSD, ODD, Hallucinations or Psychosis.</p> <p>Mood dysregulation: “The incidents while I was working with him yknow just a lot of problems with mood regulation and stuff like that and that would seem to be a significant yknow trigger for him. Any sort of incident that would cause him to become upset – or he would be yknow be challenged by authority or something, yknow kind of triggered that feeling of, I guess, frustration and he didn’t really – kind of spiraled and yknow usually ended in him resulted in being destructive or slamming his head, and banging his head, and at one point he tried to bust out a window and jump out of the window – wanted to jump out of the window. Another time he wanted to run into traffic.” P001</p>
Physical Illness	<p>Most frequent diagnoses: Poor sleep or insomnia, asthma, enuresis, frequent ear infections or ear tubes, seasonal or environmental allergies.</p> <p>P006 described many physiological conditions that may be related to suicidality in children 10 years old and younger, including: autoimmune disease (such as Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections [PANDAS] and Pediatric Acute-Onset Neuropsychiatric Syndrome [PANS]), lupus, cerebritis, encephalitis, kidney disease, glomerular disease, rheumatic fever, thyroid dysfunction, diabetes (uncontrolled), and Lyme disease.</p>
Psychiatric	<p><b>Crisis screening:</b> “Screening. Definitely qualified screeners.</p>

Interventions	<p>People that are specifically trained to be able to do that. That's the most important." (P011)</p> <p><b>Psychiatric hospitalization:</b> "If the child really isn't that safe and they really...they need somebody watching them all the time and figuring out what the best medication is for them." (P002)</p> <p><b>Psychotropic medication:</b> "Sometimes medication is definitely helpful because some of these kids I think are like a hot car engine, and you need to really like cool things down in order to really address some stuff." Later in the interview, P001 cautioned, however: "Any drug in a child is a drug in a child. I guess it's my philosophy that you want to see what you can do without meds before you start pumping them in." (P001)</p> <p><i>A total of 27 different medications were prescribed, with the most frequent being Adderall or Adderall XR (47.62%, n = 10), Risperdal or risperidone (47.62%, n = 10), and Tenex, Intuniv, or guanfacine (38.10%, n = 8).</i></p>
RESCUE Interventions	<p><b>Respond.</b> Take all warning signs, verbalizations, threats, or behaviors of childhood suicidality seriously. (P002, P004, P005, P007, P008, P009, P010, P011) Never ignore a child's suicidality. (P010, P011) Remain calm. (P001, P008, P010) Respond with compassion and empathy. (P001, P003, P004, P009, P010, and P011) Act immediately: "If you have a real concern about a kid, it needs to be addressed immediately. Because the fact is, if something happened a week ago, and the kid is just getting to the ER 5 days later, they're not going to be taken seriously. It needs to happen then!" (P004)</p> <p><b>Evaluate.</b> Ask probing questions. (P001, P003, P004, P007, P010, P011, P012) Listen to the child's full answers. (P007, P010, P012) Assess potential risks for the child and those around them (P006, P007, P008) Evaluate the child's overall wellness (P006, P011, P012)</p> <p><b>Safety.</b> Ensure safety across settings. Increase supervision by a trusted adult. (P002, P006, P007,</p>

	<p>P008, P010, P011, P012)</p> <p>"I think number one you gotta keep them safe. So number one you've got to really make sure that the environment is safe. There still has to be vigilance yknow, if they- if they are at risk. There has to be vigilance in supervision. I don't know how else you get around it." (P006)</p> <p>Limit suicidal children's access to lethal means. (P003, P004, P005)</p> <p>Individualized safety planning. (P001, P005, P011, P012)</p> <p><b>Collaborate.</b></p> <p>Provide parent education regarding childhood suicidality. (P004, P005, P006, P008, P011)</p> <p>Collaborate with a variety of treatment providers, such as mental health and school counselors, primary care physicians, school nurses, psychiatrists, and other professionals. (P007, P008, P009, P010, P011)</p> <p>Consult with clinical supervisor. (P011, P012)</p> <p><b>Understand.</b></p> <p>"Talking about feelings, sadness, letting them know that their feelings are important and what they say is important." (P005)</p> <p>Find a trusted adult. (P001, P002, P003, P004, P005, P007, P010, P012)</p> <p>Relaxation techniques. (P002, P004)</p> <p>"To prevent it from happening again, I think uhm if we had more time for individuals to make a connection, and form an alliance with the kid, and really talk with them about what this means and yknow, what is so bad and how we can work to change things in your life, I think that would probably be the most effective." (P004)</p> <p><b>Engage.</b></p> <p>"I think it's important to know that [suicidality] happens. Uhm, and that it's not like the end of the world, necessarily. And that it is a problem to be solved, like you have to work on it. And...one thing might not work. Like there's- there might be like lots of different things that you need to try. And just keep trying." (P003)</p> <p>Individual counseling.</p> <p>CBT or TF-CBT.</p> <p>Narrative or existential counseling. (P011)</p> <p>Sand tray and puppets. (P005)</p> <p>Journaling. (P010)</p>
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	<p>Psychoeducation for the child. (P011)</p> <p>“They’re not- and especially the pre-logical kid, they’re not logical. But they can express how they feel. And you can use whatever mode they’re expressing to kind of react back to them to make it better. You know, to help them heal. Uhm, I think you’ve got to do a therapeutic dance with them. (Gestures with hands a “dancing” movement.) You know, go where they are! And then just kind of...(Smiles; Gestures with hands a “back and forth” movement.) ...dance with them.” (P006)</p>
<p>Barriers to Treatment</p>	<p><b>Difficult to accurately assess childhood suicidality:</b> “It’s just really hard to know like what actually things are when they’re this young. Like it’s hard to know if it is actually suicidal ideation, or...is it...I don’t know.” (P003)</p> <p>“There isn’t literature about certain things and in this field, so many of the adults have their own ideas of what a child is going through. And that doesn’t mean that I’m correct or they’re correct or anything else, but it is definitely a problem that can prevent us from being able to spot certain things.” (P009)</p> <p>“Uhm...like I- and you even read stuff about like accidental ingestions and things like that. Yknow, when you look at the data, it seems like a lot more of those actually end up being the kid saying, “Oh yeah, I was trying to hurt myself,” than not. But a lot of these come through- I think it’s so hard because a lot of come through the ER and might get written up as an accidental overdose or something- accidental ingestion- and get discharged and we don’t ever see that. You know what I mean?” (P004)</p> <p><b>Lack of an age-appropriate assessment tool:</b>          “You take what’s appropriate for older- for like adults and adolescents and just kind of try to wing it.” (P003)</p> <p>“We have our own suicide/homicide risk assessment form. But I think it’s all really based off of data that is gathered from working with teens and adults. ...A more specified tool would be helpful.” (P005)</p> <p><b>Treatment provider feels inexperienced or unprepared:</b>          “I have to admit, yknow (Pauses; hesitation in voice)...I feel like I don’t- I have experience, but I don’t have a ton of experience....And I don’t know how helpful I can be.” (P004)</p>

“Somebody says they want to kill themselves like, even therapists won’t deal with it sometimes because they’re scared...because the potential for somebody to die, they’re scared. They don’t know what to do. It’s a big deal.” (P011)

**Myths about suicide in children:**

“We’ve had mobile response workers who say that we don’t- that our kids- they’re like, ‘Oh no, that’s too young. We can’t have mobile response for that young of a kid.’” (P003)

“I’ve had uhm resistance from parents, from administrators, from hospital staff, in taking a child under ten’s statements as factual.” (P008)

**Parents as a barrier to treatment:**

“And the mother said, ‘No, I know my daughter. She would never do that.’ And things like that. And I’m like, ‘But we absolutely have to have this checked out.’ And the mother was so angry with me for even implying that this could be a possibility. Just total denial. No way.” (P008)

“I feel like- a lot of times parents are looking for like magic fixes. Like, the answer, the diagnosis that’s going to solve everything. And that’s never the case in my experience.” (P003)

“There’s parents who want a medication and only want a medication to fix things, which doesn’t happen.” (P004)

Table 2.

*Most Frequent Observable Qualities of Suicidal Children*

Quality	<i>n</i>	Percentage	Interview Agreement
Impulsivity	16	76.19%	10
Crying or sadness	15	71.43%	5
Homicidal ideation, threats, or behaviors	14	66.67%	7
Aggression	14	66.67%	4
Mood swings or labile mood	10	47.62%	4
Poor social/communication skills	9	42.86%	4
Running away or elopement	9	42.86%	3
Oppositional defiance	9	42.86%	2
Irritability	8	38.10%	1
Tantrums	7	33.33%	6
Isolation or seems withdrawn	7	33.33%	1
Urination in inappropriate places	7	33.33%	1
Stealing or theft	7	33.33%	0
Low self-esteem	5	23.81%	4
Risky behaviors *	--	----	7
Poor self-care *	--	----	5
Attention-seeking is incorrect assumption	3	13.64%	4

*Note.* *n* = Number of treatment charts that included the code. The asterisk (\*) denotes that this code derived from interview data, for which statistics were not available.

## References

- American Association of Suicidology. (n.d.). Know the warning signs. Retrieved from <http://www.suicidology.org/resources/multimedia-resources/suicide-warning-signs>
- American Counseling Association. (2005). ACA Code of Ethics. Alexandria, VA: Author.
- American Foundation for Suicide Prevention. (2013). Risk factors and warning signs. Retrieved from <http://www.afsp.org/understanding-suicide/risk-factors-and-warning-signs>
- American Foundation for Suicide Prevention. (2014). Preventing suicide. Retrieved from <http://www.afsp.org/preventing-suicide>
- American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition. Washington, DC: Author.
- Andover, M. S., Zlotnick, C., & Miller, I. W. (2007). Childhood physical and sexual abuse in depressed patients with single and multiple suicide attempts. *Suicide and Life-Threatening Behavior*, 37, 467-474. doi: 10.1521/suli.2007.37.4.467
- Antypa, N., Serretti, A., & Rujescu, D. (2013). Serotonergic genes and suicide: A systematic review. *European Neuropsychopharmacology*, 23, 1125-1142. doi: 10.1016/j.euroneuro.2013.03.013
- Arslan, M., Akçan, R., Hilal, A., Batuk, H., & Çekin, N. (2007). Suicide among children and adolescents: Data from Çukurova, Turkey. *Child Psychiatry and Human Development*, 38, 271-277. doi:10.1007/s10578-007-0060-y

- Asarnow, J. R., Carlson, G. A., & Guthrie, D. (1987). Coping strategies, self-perceptions, hopelessness, and perceived family environments in depressed and suicidal children. *Journal of Consulting and Clinical Psychology, 55*, 361-366. doi: 10.1037/0022-006X.55.3.361
- Ash, P. (2012). [Children, Adolescents, and College Students]. In R. I. Simon & R. E. Hales (Eds.), *The American Psychiatric Publishing textbook of suicide assessment and management* (2nd ed., pp. 349-366). Washington D. C.: American Psychiatric Association.
- Barrios, L. C., Sleet, D. A., & Mercy, J. A. (2003). CDC school health guidelines to prevent unintentional injuries and violence. *American Journal of Health Education, 34*, S-18-S-22.
- Barrocas, A. L., Hankin, B. L., Young, J. F., & Abela, J. R. Z. (2012). Rates of nonsuicidal self-injury in youth: Age, sex, and behavioral methods in a community sample. *Pediatrics, 130*, 39-45. doi: 10.1542/peds.2011-2094
- Ben-Yehuda, A., Aviram, S., Govezenski, J., Nitzan, U., Levkovitz, Y., & Bloch, Y. (2012). Suicidal behavior in minors – Diagnostic differences between children and adolescents. *Journal of Developmental & Behavioral Pediatrics, 33*, 542-547. doi: 10.1097/01.DBP.0000415830.85996.e6
- Bertolote, J. M., & De Leo, D. (2012). Global suicide mortality rates – A light at the end of the tunnel? *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 33*, 249-253. doi: 10.1027/0227-5910/a000180

Blood, R. W., & Pirkis, J. (2001). Suicide and the media: Part III. Theoretical issues.

*Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 22, (163-169).

doi: 10.1027//0227-5910.22.4.163

Bondy, B., Buettner, A., & Zill, P. (2006). Genetics of suicide. *Molecular Psychiatry*, 11,

336-351. doi: 10.1038/sj.mp.4001803

Brent, D. A., & Mann, J. J. (2005). Family genetic studies, suicide, and suicidal behavior.

*American Journal of Medical Genetics Part C (Seminars in Medical Genetics)*,

133C, 13-24. doi: 10.1002/ajmg.c.30042

Capuzzi, D. (1994). *Suicide prevention in the schools: Guidelines for middle and high school settings*. Alexandria, VA: American Counseling Association.

Centers for Disease Control and Prevention. (2013). Fatal injury reports, National and regional, 1999 – 2010. Retrieved from

[http://www.cdc.gov/injury/wisqars/fatal\\_injury\\_reports.html](http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html)

Centers for Disease Control and Prevention. (2012a). Injury prevention & control.

Definitions: Self-directed violence. Retrieved from

<http://www.cdc.gov/violenceprevention/suicide/definitions.html>

Centers for Disease Control and Prevention. (2012b). *Suicide: Facts at a glance* [Fact sheet]. Author. Retrieved from

<http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf>

Centers for Disease Control and Prevention. (2012c). Injury center: Violence prevention.

Retrieved from [http://www.cdc.gov/violenceprevention/pub/youth\\_suicide.html](http://www.cdc.gov/violenceprevention/pub/youth_suicide.html)

- Charles, G., & Matheson, J. (1991). Suicide prevention and intervention with young people in foster care in Canada. *Child Welfare: Journal of Policy, Practice, and Program*, 70, 185-191.
- Charmaz, K. (2008). *Introducing Qualitative Methods: Constructing grounded theory: A practical guide through qualitative analysis*. Los Angeles, CA: Sage.
- Charmaz, K. (2012). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Cheng, Y., Tao, M., Riley, L., Kann, L., Ye, L., Tian, X., . . . Hu, J. (2009). Protective factors relating to decreased risks of adolescent suicidal behaviour. *Child: Care, Health and Development*, 35, 313-322. doi:10.1111/j.1365-2214.2009.00955.x
- Corbin, J. & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage.
- Council for the Accreditation of Counseling and Related Educational Programs (2009). CACREP Accreditation Manual. Alexandria, VA: Author.
- Creswell, J. W. (2007) *Qualitative inquiry and research design: Choosing among five approaches* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Crosby, A. E., Han, B., Ortega, L. A. G., Parks, S., & Gfroerer, J. (2011). Suicidal thoughts and behaviors among adults aged  $\geq 18$  years – United States, 2008-2009. *MMWR Surveillance Summaries*, 60, 1-22.
- Cwik, M. F., & Walkup, J. T. (2008). Can randomized controlled trials be done with suicidal youths? *International Review of Psychiatry*, 20, 177-182. doi: 10.1080/09540260801889104

- Davis, T. (2004). Counseling Suicidal Children. In D. Capuzzi (Ed.), *Suicide across the lifespan: Implications for counselors* (pp. 211-234). Alexandria, VA: American Counseling Association.
- Department of Children and Families of the State of New Jersey (2014). Defining child abuse and neglect. Retrieved from <http://www.nj.gov/dcf/reporting/defining/>
- Dervic, K., Friedrich, E., Oquendo, M. A., Voracek, M., Friedrich, M. H., & Sonneck, G. (2006). Suicide in Austrian children and young adolescents aged 14 and younger. *European Child & Adolescent Psychiatry*, 15, 427-434. doi:10.1007/s00787-006-0551-6
- Dongfeng, M., Zhang, Z., Zhang, X., & Li, L. (2014). Comparative efficacy, acceptability, and safety of medicinal, cognitive-behavioral therapy, and placebo treatments for acute major depressive disorder in children and adolescents: A multiple-treatments meta-analysis. *Current Medical Research and Opinion*, 30, 971-995. doi: 10.1185/03007995.2013.860020
- Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology*, 52, 156-166. doi: 10.1037/0022-0167.52.2.156
- Fernquist, R. M. (2000). Problem drinking in the family and youth suicide. *Adolescence*, 35, 551-558.
- Fite, P. J., Stoppelbein, L., Greening, L., & Preddy, T. M. (2011). Associations between relational aggression, depression, and suicidal ideation in a child psychiatric inpatient sample. *Child Psychiatry & Human Development*, 42, 666-678. doi:10.1007/s10578-011-0243-4

- Flannery, D. J. (2006). *Violence Prevention and Policy Series: Violence and mental health in everyday life: Prevention and intervention strategies for children and adolescents*. New York, NY: AltaMira Press.
- Foley, D. L., Goldston, D. B., Costello, E. J., & Angold, A. (2006). Proximal psychiatric risk factors for suicidality in youth: The Great Smoky Mountains study. *Archives of General Psychiatry*, 63, 1017-1024. doi: 10.1001/archpsyc.63.9.1017
- Forbes, F. C. M. (1998). Children with enuresis. *British Medical Journal*, 316, 777.
- Gasior, D., & Underwood, M. (2011). Parent awareness series: I am worried about my child. Freehold, NJ: Society for the Prevention of Teen Suicide.
- Geertz, C. (1973). *The interpretation of cultures*. New York: Basic Books.
- Giard v. Town of Putnam, No. CV085002754S, 2008 Conn. Super. LEXIS 3149, at \*1, slip op. (Superior Court of Connecticut, Judicial District of Windham Dec. 3, 2008).
- Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.
- Goldston, D. (2003). *Measuring suicidal behavior and risk in children and adolescents*. Washington, D.C.: American Psychological Association.
- Greening, L., Stoppelbein, L., Luebke, A., & Fite, P. J. (2010). Aggression and the risk for suicidal behaviors among children. *Suicide and Life-Threatening Behavior*, 40, 337-345. doi: 10.1521/suli.2010.40.4.337
- Grossman, D. C., Mueller, B. A., Riedy, C., Dowd, M. D., Villaveces, A., Prodzinski, J., ...Harruff, R. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. *Journal of the American Medical Association*, 293, 707-714. doi: 10.1001/jama.293.6.707

- Haley, M. (2004). Risk and Protective Factors. In D. Capuzzi (Ed.), *Suicide across the lifespan: Implications for counselors* (pp. 211-234). Alexandria, VA: American Counseling Association.
- Hawton, K., Bergen, H., Kapur, N., Cooper, J., Steeg, S., Ness, J., & Waters, K. (2012). Repetition of self-harm and suicide following self-harm in children and adolescents: Findings from the Multicentre Study of Self-Harm in England. *Journal of Child Psychology and Psychiatry*, 53, 1212-1219. doi: 10.1111/j.1469-7610.2012.02559.x
- Hawton, K., & Harriss, L. (2008). Deliberate self-harm by under-15-year-olds: characteristics, trends and outcome. *The Journal of Child Psychology and Psychiatry*, 49, 441-448. doi:10.1111/j.1469-7610.2007.01852.x
- Hawton, K., & Williams, K. (2001). The connection between media and suicidal behavior warrants serious attention. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 22, 137-140. doi: 10.1027//0227-5910.22.4.137
- Hays, D. G. & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. New York, NY: Guilford Press.
- Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs. *Journal of Counseling & Development*, 89, 288-295. doi: 10.1002/j.1556-6678.2011.tb00091.x
- Helsel, D. C. (2001). Does your school track the suicidal student? *The Clearing House*, 75, 92-95.

- Hepp, U., Stulz, N., Unger-Köppel, J., & Ajdacic-Gross, V. (2012). Methods of suicide used by children and adolescents. *European Child & Adolescent Psychiatry, 21*, 67-73. doi: 10.1007/s00787-011-0232-y
- Hinshaw, S. P., Owens, E. B., Zalecki, C., Huggins, S. P., Montenegro-Nevado, A., Schrodek, E., & Swanson, E. N. (2012). Prospective follow-up of girls with attention-deficit/hyperactivity disorder into early adulthood: Continuing impairment includes elevated risk for suicide attempts and self-injury. *Journal of Consulting and Clinical Psychology, 80*, 1041-1051. doi: 10.1037/a0029451
- Holtmann, M., Buchmann, A. F., Esser, G., Schmidt, M. H., Banaschewski, T., & Laucht, M. (2011). The Child Behavior Checklist-Dysregulation Profile predicts substance abuse, suicidality, and functional impairment: a longitudinal analysis. *Journal of Child Psychology and Psychiatry, 52*, 139-147. doi:10.1111/j.1469-7610.2010.02309.x
- Holton, J. A. (2007). [The Coding Process and Its Challenges]. In A. Bryant and K. Charmaz (Eds.), *The SAGE handbook of grounded theory* (pp. 265-289). Thousand Oaks, CA: Sage.
- Horowitz, L. M., Wang, P. S., Koocher, G. P., Burr, B. H., Smith, M. F., Klavon, S., & Cleary, P. D. (2001). Detecting suicide risk in a pediatric emergency department: Development of a brief screening tool. *Pediatrics, 107*, 1133-1137.
- Hsieh, H-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*, 1277-1288. doi: 10.1177/1049732305276687
- Huey, S. J., Jr., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C. A., Cunningham, P. B., & Pickrel, S. G. (2005). Predictors of treatment response for

- suicidal youth referred for emergency psychiatric hospitalization. *Journal of Clinical Child & Adolescent Psychology*, 34, 582-589.  
doi:10.1207/s15374424jccp3403\_13
- Jackson, H., Hess, P. M., van Dalen, A. (1995). Preadolescent suicide: How to ask and how to respond. *Families in Society*, 76, 267-279.
- Johnson-Reid, M., Kohl, P. L., & Drake, B. (2012). Child and adult outcomes of chronic child maltreatment. *Pediatrics* 129, 839-845. doi: 10.1542/peds.2011-2529
- Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.
- Joiner, T. (2010). *Myths about suicide*. Cambridge, MA: Harvard University.
- Kashani, J. H., Goddard, P., & Reid, J. C. (1989). Correlates of suicidal ideation in a community sample of children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 912-917. doi: 10.1097/00004583-198911000-00016
- King, C. A., Jiang, Q., Czyz, E. K., & Kerr, D. C. R. (2013). Suicidal ideation of psychiatrically hospitalized adolescents has one-year predictive validity for suicide attempts in girls only. *Journal of Abnormal Child Psychology*, no pagination specified. doi: 10.1007/s10802-013-9794-0
- Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy*, 45, 214-222. doi: 10.5014/ajot.45.3.214
- Labonte, B., & Turecki, G. (2010). The epigenetics of suicide: Explaining the biological effects of early life environmental adversity. *Archives of Suicide Research*, 114, 291-310. doi: 10.1080/13811118.2010.524025

- Larzelere, R. E., Andersen, J. J., Ringle, J. L., & Jorgensen, D. D. (2004). The Child Suicide Risk Assessment: A screening measure of suicide risk in pre-adolescents. *Death Studies*, 28, 809-827. doi: 10.1080/07481180490490861
- Lau, A. S., Jernewall, N. M., Zane, N., & Myers, H. F. (2002). Correlates of suicidal behavior among Asian American outpatient youths. *Cultural Diversity & Ethnic Minority Psychology*, 8, 199-213. doi: 10.1037/1099-9809.8.3.199
- Lopez-Castroman, J., Jaussent, I., Beziat, S., Genty, C., Oli , E., de Leon-Martinez, V., ... Guillaume, S. (2012). Suicidal phenotypes associated with family history of suicidal behavior and early traumatic experiences. *Journal of Affective Disorders*, 142, 193-199. doi: 10.1016/j.jad.2012.04.025
- Luby, J. L. (2009). Depression. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (3rd ed., pp. 409-420). New York, NY: Guilford Press.
- Mata, A. D., van Dulmen, M. H. M., Schinka, K. C., Swahn, M. H., Bossarte, R. M., & Flannery, D. J. (2012). Extracurricular activity involvement is associated with adolescent suicidality through school belongingness. *Vulnerable Children and Youth Studies*, 7, 347-356. doi: 10.1080/17450128.2012.708463
- Mayes, S. D., Gormann, A. A., Hillwig-Garcia, J., & Syed, E. (2013). Suicide ideation and attempts in children with Autism. *Research in Autism Spectrum Disorders*, 7, 109-119. doi: 10.1016/j.rasd.2012.0.009
- Mazza, J. J. (2006). Youth suicidal behavior: A crisis in need of attention. In F. A. Villarruel & T. Luster (Eds.), *The crisis in youth mental health: Critical issues and effective programs: Vol. 2. Disorders in adolescence* (pp. 155-177). Westport, CT: Praeger.

- McDougall, T., Armstrong, M., & Trainor, G. (2010). *Helping children and young people who self-harm: An introduction to self-harming and suicidal behaviours for health professionals*. New York, NY: Routledge.
- McGlothlin, J. M. (2008). *Developing clinical skills in suicide assessment, prevention, and treatment*. Alexandria, VA: American Counseling Association.
- McIntyre, L., Williams, J. V. A., Lavorato, D. H., Patten, S. (2012). Depression and suicide ideation in late adolescence and early adulthood are an outcome of child hunger. *Journal of Affective Disorders*, no pagination specified. doi: 10.1016/j.jad.2012.11.029
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Miller, D. N., & Eckert, T. L. (2009). Youth suicidal behavior: An introduction and overview. *School Psychology Review*, 38, 153-167.
- Mishara, B. L. (1999). Conceptions of death and suicide in children ages 6-12 and their implications for suicide prevention. *Suicide and Life-Threatening Behavior*, 29, 105-118. doi: 0.1111/j.1943-278X.1999.tb01049.x
- Mojtabai, R., & Olfson, M. (2008). Parental detection of youth's self-harm behavior. *Suicide and Life-Threatening Behavior*, 38, 60-73. doi: 10.1521/suli.2008.38.1.60
- Mosiri, N. (2010, September 23). Rising suicide rate baffles Greenland: Natural beauty of Greenland belies a secret in a place in which almost every citizen knows someone who has taken their own life. [Blog post]. Retrieved from <http://blogs.aljazeera.com/blog/Europe/rising-suicide-rate-baffles-greenland>

National Institute of Mental Health. (n.d.). Autism. Retrieved April 21, 2013, from  
[http://www.nimh.nih.gov/statistics/1AUT\\_CHILD.shtml](http://www.nimh.nih.gov/statistics/1AUT_CHILD.shtml)

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

O'Connell, K. L. (2012). Child and Adolescent Suicide. *Journal of Child and Adolescent  
 Psychiatric Nursing*, 25, 111–112. doi: 10.1111/j.1744-6171.2012.00333.x

O'Neil, K. A., Puleo, C. M., Benjamin, C. L., Podell, J. L., & Kendall, P. C. (2012).  
 Suicidal ideation in anxiety-disordered youth. *Suicide and Life-Threatening  
 Behavior*, 42, 305-317. doi: 10.1111/j.1943-278X.2012.00091.x

Oshima, N., Nishida, A., Shimodera, S., Tochigi, M., Ando, S., Yamasaki, S., ... Sasaki,  
 T. (2012). The suicidal feelings, self-injury, and mobile phone use after lights out  
 in adolescents. *Journal of Pediatric Psychology*, 37, 1023-1030. doi:  
 10.1093/jpepsy/jss072

Paykel, E. S. (1991). Stress and life events. In Davidson, L. and Linnoila, M. (Eds.)  
*Death education, aging and health care: Risk factors for youth suicide*. New  
 York: Hemisphere.

Perroud, N., Courtet, P., Vincze, I., Jaussent, I., Jollant, F., Bellivier, F., ... Malafosse, A.  
 (2008). Interaction between BDNF Val66Met and childhood trauma on adult's  
 violent suicide attempt. *Genes, Brain and Behavior*, 7, 314-322. doi:  
 10.1111/j.1601-183X.2007.00354.x

Pfeffer, C. A. (1986). *The suicidal child*. New York, NY: Guilford.

- Pomerantz, W., Gittelman, M., Farris, S., & Frey, L. (2009). Drug ingestions in children 10-14 years old: An old problem revisited. *Suicide and Life-Threatening Behavior*, 39, 433-439. doi: 10.1521/suli.2009.39.4.433
- Pompili, M., Mancinelli, I, Girardi, P., Ruberto, A., & Tatarelli, R. (2005). Childhood suicide: A major issue in pediatric health care. *Issues in Comprehensive Pediatric Nursing*, 28, 63-68.
- Popenhagen, M. P., & Qualley, R. M. (1998). Adolescent suicide: Detection, intervention, and prevention. *Professional School Counseling*, 1 (4), 30-35.
- Qin, P., Agerbo, E., & Mortensen, P. B. (2002). Suicide risk in relation to family history of completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers. *Lancet*, 360, 1126-1130. doi: 10.1016/S0140-6736(02)11197-4
- Rajalin, M., Hirvikoski, T., & Jokinen, J. (2012). Family history of suicide and exposure to interpersonal violence in childhood predict suicide in male suicide attempters. *Journal of Affective Disorders*, no pagination specified.  
doi:10.1016/j.jad.2012.11.055
- Ramey, H. L., Busseri, M. A., Khanna, N., Hamilton, Y. N., Ottawa, Y. N. R. A., & Rose-Krasnor, L. (2010). Youth engagement and suicide risk: Testing a mediated model in a Canadian community sample. *Journal of Youth and Adolescence*, 39, 243-258. doi: 10.1007/s10964-009-9476-y
- Range, L. M. (1993). Suicide prevention: Guidelines for schools. *Educational Psychology Review*, 5, 135-154.

Rhodes, A. E., Boyle, M. H., Bethell, J., Wekerle, C., Goodman, D., Tonmyr, L., ...

Manion, I. (2012). Child maltreatment and onset of emergency department presentations for suicide-related behaviors. *Child Abuse & Neglect*, 36, 542-551. doi:10.1016/j.chiabu.2012.04.006

Rideout, V. J., Foehr, U. G., & Roberts, D. F. (2010, January). *Generation M<sup>2</sup>: Media in the lives of 8- to 18-year olds*. Menlo Park, CA: Henry J. Kaiser Family Foundation.

Riesch, S. K., Jacobson, G., Sawdey, L., Anderson, J., & Henriques, J. (2008). Suicide ideation among later elementary school-aged youth. *Journal of Psychiatric and Mental Health Nursing*, 15, 263-277. doi: 10.1111/j.1365-2850.2007.01221.x

Rogers, J. R., & Soyka, K. M. (2004). "One Size Fits All": An existential-constructivist perspective on the crisis intervention approach with suicidal individuals. *Journal of Contemporary Psychotherapy*, 34, 7-22. doi: 10.1023/B:JOCP.0000010910.74165.3a

Roggenbaum, S., Christy, A., & LeBlanc, A. (2012). Suicide assessment and prevention during and after emergency commitment. *Community Mental Health Journal*, 48, 741-745. doi: 10.1007/s10597-011-9428-3

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

Schutz, A. (1967 [1932]). *The phenomenology of the social world*. Evanston, IL: Northwestern University Press.

Shamoo, T. K., & Patros, P. G. (1997). *The Jossey-Bass Psychology Series: Helping your child cope with depression and suicidal thoughts*. San Francisco, CA: Jossey-

- Bass. (Original work published 1990: "I want to kill myself" Lexington, MA: Lexington Books.)
- Siegal, M. (2008). Life and death. In *Marvelous minds: The discovery of what children know* (pp. 99-115). New York, NY: Oxford University Press.
- Singer, J. B., & Slovak, K. (2011). School social workers' experiences with youth suicidal behavior: An exploratory study. *Children & Schools, 33*, 215-228. doi: 10.1093/cs/33.4.215
- Skala, K., Kapusta, N. D., Sclaff, G., Unseld, M., Erfurth, A., Lesch, O., ... Akiskal, H. S. (2012). Suicidal ideation and temperament: An investigation among college students. *Journal of Affective Disorders, 141*, 399-405. doi: 10.1016/j.jad.2012.03.010
- Skinner, R., & McFaull, S. (2012). Suicide among children and adolescents in Canada: Trends and sex differences, 1980-2008. *Canadian Medical Association Journal, 184*, 1029-1034. doi: 10.1503/cmaj.111867
- Strauss, A., & Corbin, J. (1998). Basics of qualitative research: *Grounded theory procedures and techniques* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Tamas, Z., Kovacs, M., Gentzler, A. L., Tepper, P., Gadoros, J., Kiss, E., . . . Vetro, A. (2007). The relations of temperament and emotion self-regulation with suicidal behaviors in a clinical sample of depressed children in Hungary. *Journal of Abnormal Child Psychology, 35*, 640-652. doi:10.1007/s10802-007-9119-2
- Tishler, C. L. (1980). Intentional self-destructive behavior in children under age ten. *Clinical Pediatrics, 19*, 451-453.

- Tishler, C. L., Reiss, N. S., & Rhodes, A. R. (2007). Suicidal behavior in children younger than twelve: A diagnostic challenge for emergency department personnel. *Academic Emergency Medicine, 14*, 810-818. doi: 10.1197/j.aem.2007.05.014
- Valle, V., Gosney, H., & Sinclair, J. (2008). Qualitative analysis of coroner's data into the unnatural deaths of children and adolescents. *Child: Care, Health and Development, 34*, 721-731. doi: 10.1111/j.1365-2214.2008.00858.x
- Walsh, E., Hooven, C., & Kronick, B. (2013). School-wide staff and faculty training in suicide risk awareness: Successes and challenges. *Journal of Child and Adolescent Psychiatric Nursing, 26*, 53-61. doi: 10.1111/jcap.12011
- Wasserman, G. A., & McReynolds, L. S. (2006). Suicide risk at juvenile justice intake. *Suicide and Life-Threatening Behavior, 36*, 239-249. doi: 10.1521/suli.2006.36.2.239
- Whetstone, L. M., Morrissey, S. L., & Cummings, D. M. (2007). Children at risk: The association between perceived weight status and suicidal thoughts and attempts in middle school youth. *Journal of School Health, 77*, 59-66. doi:10.1111/j.1746-1561.2007.00168.x
- Windfuhr, K., While, D., Hunt, I., Turnbull, P., Lowe, R., Burns, J., . . . Kapur, N. (2008). Suicide in juveniles and adolescents in the United Kingdom. *Journal of Child Psychology and Psychiatry, 49*, 1155-1165. doi:10.1111/j.1469-7610.2008.01938.x

- World Health Organization. (2010). Suicide prevention. In *Distribution of suicide rates (per 100,000) by gender and age, 2005* [Fact sheet]. Retrieved from [http://www.who.int/mental\\_health/media/unitstates.pdf](http://www.who.int/mental_health/media/unitstates.pdf)
- World Health Organization. (2013). Mental health: Country reports and charts available [Fact sheets]. Retrieved from [http://www.who.int/mental\\_health/prevention/suicide/country\\_reports/en/](http://www.who.int/mental_health/prevention/suicide/country_reports/en/)
- Yip, P. S. F., & Law, Y. (2010). *Towards evidence-based suicide prevention programmes*. Geneva, Switzerland: World Health Organization: Western Pacific Region.
- Youth Suicide Prevention Program. (2011). Riding the waves elementary school curriculum. Retrieved from [http://www.yspp.org/curriculum/RidingWaves\\_curriculum.htm](http://www.yspp.org/curriculum/RidingWaves_curriculum.htm)
- Zapata, L. B., Kissin, D. M., Bogoliubova, O., Yorick, R. V., Kraft, J. M., Jamieson, D. J., ... Hillis, S. D. (2013). Orphaned and abused youth are vulnerable to pregnancy and suicide risk. *Child Abuse & Neglect*, no pagination specified. doi: 10.1016/j.chiabu.2012.10.005
- Zenere, F. J., & Lazarus, P. J. (2009). The sustained reduction of youth suicidal behavior in an urban, multicultural school district. *School Psychology Review*, 38, 189-199.

Appendix A-1. IRB Approval Letter

December 12, 2013

Approved Application Number 201401055

Dr. Danica Hays  
Department of Counseling and Human Services

Dear Dr. Hays:

Your Application for Exempt Research with Katherine A. Heimsch and Heather D. Dahl entitled "A Grounded Theory of Suicidality in Children Ten and Younger," has been found to be EXEMPT under Categories 6.2 & 6.4 from IRB review by the Human Subjects Review Committee of the Darden College of Education. You may begin this research project when you are ready.

The determination that this study is EXEMPT from IRB review is for an indefinite period of time provided no significant changes are made to your study. If any significant changes occur, notify me or the chair of this committee at that time and provide complete information regarding such changes.

In the future, if this research project is funded externally, you must submit an application to the University IRB for approval to continue the study.

Best wishes in completing your study.

Sincerely,

Theodore P. Remley, Jr., J.D., Ph.D.  
Professor and Batten Endowed Chair in Counseling  
Department of Counseling and Human Services  
ED 110  
Norfolk, VA 23529

Chair  
Darden College of Education Human Subjects Review Committee  
Old Dominion University

[tremley@odu.edu](mailto:tremley@odu.edu)

## Appendix A-2. Informed Consent Form

**INFORMED CONSENT DOCUMENT****OLD DOMINION UNIVERSITY****PROJECT TITLE:** A Grounded Theory of Suicidality in Children Ten and Younger**INTRODUCTION**

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES.

**RESEARCHERS**

Danica G. Hays, Responsible Principal Investigator, Ph.D., Darden College of Education,  
Counseling and Human Services Department  
Katherine A. Heimsch, Primary Investigator  
Heather D. Dahl, Investigator  
Hsin-Ya Tang, Investigator

**DESCRIPTION OF RESEARCH STUDY**

Several studies have been conducted looking into the subject of suicidality as it affects young people. None of them have explained the phenomenon of suicidality exclusively amongst children ten years and younger.

If you decide to participate, then you will join a study involving research of advanced treatment providers of suicidal children. The Primary Investigator will collect qualitative data regarding the characteristics of childhood suicidality, the factors that influence childhood suicidality, and the treatment implications for children ten and younger who experience suicidality. Data will be collected through individual interviews with treatment providers (counselors, marriage & family therapists, social workers, psychologists, psychiatrists, etc.) who have been trained in suicidality, and who have worked for at least one year with one or more suicidal children. These interviews will be audio and/or videotaped, transcribed, and then checked with you for accuracy.

If you say YES, then your participation will last for approximately one hour at a private location of your choice. The Primary Investigator may also request your review of the interview's transcription. Approximately 20 advanced treatment providers of suicidal children will be participating in this study.

**EXCLUSIONARY CRITERIA**

You should have completed the Eligibility Questionnaire. To the best of your knowledge, you should not have less than a graduate degree in a counseling or related field, less than one year of experience working with suicidal children, or less than one training (through an educational course or professional continuing education credit) in suicidality, that would keep you from participating in this study.

### **RISKS AND BENEFITS**

**RISKS:** If you decide to participate in this study, then you may face a risk of discomfort in discussing your experiences with young clients who have experienced suicidality. The researcher tried to reduce these risks by removing all linking identifiers to your reported experiences. And, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

**BENEFITS:** The main benefit to you for participating in this study is free psychoeducational materials pertaining to children's suicidality that will be created following this investigation.

### **COSTS AND PAYMENTS**

The researchers want your decision about participating in this study to be absolutely voluntary. Yet they recognize that your participation may pose some inconvenience due to the one-hour time commitment. In order to avoid conflicts in your work schedule, the Primary Investigator will offer to meet you at a time and location that is convenient to you. The researchers are unable to give you any payment for participating in this study. However, all participants will be entered in a drawing for one \$50 gift card to a major online retailer.

### **NEW INFORMATION**

If the researchers find new information during this study that would reasonably change your decision about participating, then they will inform you.

### **CONFIDENTIALITY**

All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications, but the researcher will not identify you.

### **WITHDRAWAL PRIVILEGE**

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time. The researchers reserve the right to withdraw your participation in this study, at any time, if they observe potential problems with your continued participation.

### **COMPENSATION FOR ILLNESS AND INJURY**

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of emotional distress arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Katherine A. Heimsch at the following phone number: (609) 802-1959, or Dr. Ted Remley, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at [tremley@odu.edu](mailto:tremley@odu.edu), who will be glad to review the matter with you.

**VOLUNTARY CONSENT**

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Danica G. Hays: dhays@odu.edu

Katherine A. Heimsch: kheim002@odu.edu

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should contact Dr. Ted Remley, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at [tremley@odu.edu](mailto:tremley@odu.edu).

And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study.

<b>Participant's Printed Name &amp; Signature</b>	<b>Date</b>
---	-------------

**INVESTIGATOR'S STATEMENT**

I certify that I have explained to this participant the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the participant's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

<b>Investigator's Printed Name &amp; Signature</b>	<b>Date</b>
--	-------------

## Appendix A-3. Participant Demographic Form

**A Grounded Theory of Suicidality in Children Ten and Younger**

Katherine A. Heimsch, Primary Investigator

**Participant Profile**

1. Gender:

Female

Male

Transgender

2. Age:

21-29

30-39

40-49

50-59

60-69

70-79

3. Race(s):

White/European American

Black/African American

Hispanic/Latino

Asian

American Indian/Alaska Native

Pacific Islander/Native Hawaiian

Other not specified: \_\_\_\_\_

4a. Religious/Spiritual Orientation:

Agnostic

Atheist

Buddhist

Christian

Hindu

Jewish

Muslim

Other not specified: \_\_\_\_\_

4b. *Are you:*

Non-Practicing

Somewhat Practicing

Practicing

5a. Highest Educational Attainment:

Graduate (M.A., M.S., M.S.Ed., M.S.W.) Specify: \_\_\_\_\_

Post-Graduate (Ed.S.) Specify: \_\_\_\_\_

Doctorate/Terminal Degree (Ph.D., M.D., Ed.D., Psy.D.) Specify: \_\_\_\_\_

5b. Educational Institution/Location: \_\_\_\_\_

5c. Degree Conferred Date: \_\_\_\_\_

6. Professional License(s) and Certification(s): \_\_\_\_\_

---

(May include: LAC, LPC, LCSW, LMFT, ATR, NCC, etc.)

7. Length of Post-Graduate work in Counseling or Related Field: \_\_\_\_ Years \_\_\_\_ Months  
(Related fields for the purposes of this project include Counselor Education, Psychology, Psychiatry, Social Work, and Medicine)

8a. Current Employer: \_\_\_\_\_

8b. Current Position Title: \_\_\_\_\_

8c. Length of time in this role: \_\_\_\_ Years \_\_\_\_ Months

8d. Workplace Setting:

New Jersey –            Urban            Suburban            Rural

Pennsylvania –            Urban            Suburban            Rural

Other State: \_\_\_\_\_ Urban            Suburban            Rural

8e. Clients' Primary Socioeconomic Status:

Lower SES            Middle SES            Upper SES

8f. I primarily serve clients of the following age group(s):

Infancy (0-2 years)

Preschool (3-5 years)

Elementary (5-10 years)

Pre-Adolescent (10-12 years)

Adolescent (13-17 years)

Adult (18 years +)

9. I have worked with approximately this **number of suicidal children** in the past:  
 ("Suicidal" includes: ideation, behaviors, attempts, and completions)

One (1)      A few (2-3)      Several (4-5)      Many (6-10)      More than 10 (11+)

10. Combined, I have this many **years of working with suicidal children**:

1 year      2-3 years      4-5 years      More than 5 years - Specify: \_\_\_\_\_

11. I have worked with children who have presented with:

Suicidal ideation: (Examples: thoughts, or comments)	Yes	No
Suicidal behaviors: (Examples: cutting, putting self in harm's way)	Yes	No
Suicide attempts: (Example: made serious gestures to end their life with or without hospitalization)	Yes	No
Completed suicide: (Example: client died)	Yes	No

12a. I have completed specific training on suicide in the past, including:

An educational course in my degree program.

Professional continuing education.

12b. In total, I have completed \_\_\_\_\_ (#) **Hours of training in suicide**.

12c. My training on suicidality included specific information on the following population(s):

Children Under Age 10

Pre-Adolescents (10-12 years)

Adolescents (13-17 years)

Adults (18 years +)

#### Appendix A-4. Interview Protocol

1. Tell me about your experiences with children's suicidality in your caseload/practice.

*How prevalent is childhood suicidality in your caseload or practice?*

*Can you describe the most powerful experience you have had with a suicidal child?*

*What factors, if any, do you feel contributed to the child/children's experience of suicidality?*

*What challenges or barriers, if any, do you face as a clinician working with suicidal children?*

2. How have you first recognized that a child in your caseload/practice was suicidal?

*How might children present differently than adolescents or adults, if at all?*

*What are the specific characteristics or warning signs, if any, of a child who presents with suicidality?*

*Have you utilized and/or found any formal assessments helpful?*

3. What do you think are the most important interventions and modalities, if any, for suicidal children?

*How do you determine the most appropriate interventions for the suicidal children that you have worked with?*

*How do you think other adults (parents, teachers, and mental health professionals) could best act if they suspect a child is suicidal?*

4. What do you think is most important for people to know about suicidality in children?
5. Is there anything I have not asked that you think would help me to better understand childhood suicidality?

## Appendix A-5. Treatment Chart Data Collection Form

Item	CHART STUDY NUMBER	
1	Child's Age at Intake/Discharge	
2	Gender	
3	Family Constellation Info.	
4	Socioeconomic Status	
5	Race/Ethnicity	
6	Religious Affiliation	
7	Psychiatric Diagnosis/es	
8	Medication Profile/History	
9	School History (Disciplinary actions, Tardiness, Absences, etc.)	
10	Significant Medical Issues	

11	<b>History of Substance Use/Addiction</b>	
12	<b>Age of Suicidality Onset/Duration</b>	
13	<b>Presence/Frequency of Ideation</b>	
14	<b>Presence/Frequency of Verbalizations &amp; Threats</b>	
15	<b>Presence/Frequency/Method of Suicidal Behaviors</b>	
16	<b>Presence/Frequency/Method of Suicidal Attempt</b>	
17	<b>Presence of Intent to Die</b>	
18	<b>Presence of Distinct Plan</b>	

19	<b>Other Characteristics of Suicidality</b>	
20	<b>History &amp; Severity of Abuse/Neglect</b>	
21	<b>Witness to violence</b>	
22	<b>Familial History of Mental Illness</b>	
23	<b>Familial History of Suicidality</b>	
24	<b>Exposure to others' suicidality</b>	
25	<b>Concerns about parenting/Involvement with DYFS</b>	

26	<b>Child's attachment/relationship with parent(s)</b>	
27	<b>Chaos in home/environment</b>	
28	<b>Child's behavior linked to attention-seeking</b>	
29	<b>Other Possible Triggers of Suicidality</b>	
30	<b>History of services (modalities/interventions)</b>	
31	<b>Other significant notes:</b>	
32	<b>Strengths:</b>	

## Appendix A-6. A priori Codebook

Themes & Codes	Quotes	Interviewee: Lines
		Quoted lines in <b>BOLD</b>
<b>Definitions of Suicidal Behavior</b>		
Children may specifically verbalize that they want to die, or they may not. Either way, the child may engage in suicidal behaviors.	A. "I hear kids verbalize, 'I wanna die.' " B. "...they often don't verbalize, 'I want to die.' "	<b>1:539; 1:176-177; 2:106</b>
Rage/Anger/Destruction	A. "...so often the self-destructive behaviors are an expression of intense rage, in a fashion that shows no regard for well being whatsoever." B. "and they have no regard for their well being during these kind of, absolute rage storms." C. "The intent is to destroy the rage within me."	<b>1:158-159; 1:205-206; 1:221; 1:374; 1:388; 1:404; 1:463-465; 2:15-18; 2:55-57; 2:94-97; 2:257-260; 2:281-282</b>
Negative perception of Self: Feels like a monster. "I'm bad."	A. "And he feels like a monster." B. "...he again, is another one who says, 'I am a monster. I am bad.' Right? You know, both those kids feel that they are really bad."	<b>1:185; 1:199-200; 1:638-639; 2:106-108</b>
Self-harm: Uncontrollable behavior, Head banging; No regard for safety.	A. "...he just dashed off with no regard for cars...To me, that's a serious...That's serious suicidal behavior." B. The child did not see it as suicidal: "He ran out because he didn't want his mother in program, so he ran away with reckless disregard of his wellbeing. Okay, so he doesn't see that running as suicidal...He said that was separate from wanting to die, which he sometimes feels."	<b>1:348-352; 1:981-988; 2:14; 2:72-75</b>

No distinct plan, method, means	A. "But as I said, she's the little girl I was just talking about - she had no formed idea of how she wants to die. And the only thing that she could tell me is she wants to die so that no one will tell her what to do, and she'll be completely free." B. "And no - even though they put her in Kennedy, as far as I could determine, and I read through the records really carefully - and I went through you know, the hospital records and everything - there was no intent, no plan...just the words, 'I wanna die.' "	<b>1:557-559; 1:568-571</b>
Avoidance: Don't want to live or feel anything anymore. Death is a way to "escape this earth"	A. "And she still says, "Sometimes I want to die." But what does that mean to her? It means to her that she won't ever have to listen to anybody telling her what to do. And if I die, I'm completely free to do what I want to do." B. "So her idea of dying is you...you escape this earth."	<b>1:241-243; 1:563-564; 2:43-44</b>
Not: pills, hanging, suffocation, cutting	"In children it is really really rare that I see that."	<b>1:530-535</b>
<b>Age of Understanding Suicide</b>		
Don't know permanency/finality	A. "...children just don't really get the finality of death." Children understand death at age 7 or 8. After this, "They have a much better idea of...that death is final, it's not reversible, you don't come back if you want to. You know, magical thinking has changed and children are not in that stage of thinking anymore...They're moving into operational thinking and they understand the finality of death. Whereas, I think much before that, kids don't have a solid idea of death. They have it, but then they don't hold on to it." B. "What does forever mean? That's really the issue. They get that something dies. But I don't think they really grasp...being finality and the irreversibility until they get a little bit older." C. "...there are cases where some kids that I've worked with who are four years old understand and know very	<b>1:753; 1:1313-1341; 2:23-28</b>

	<i>clearly that if they do this to themselves, they will be gone forever. And they don't want to be here anymore, and that's what they want to happen. But I think for the majority of children under ten, uhm...they don't really understand it until seven or eight or older than that."</i>	
Don't understand suicide under age 10	A. "Some of the kids that I think are in danger to themselves do not have clear understanding of their suicidal ideation." B. <i>"They may say that they want to hurt or kill themselves but they don't understand it."</i> C. <i>"I would say out of all of the kids that we've had over the course of three or four years, uhm...I think only really two of them have understood what it really means to kill themselves."</i>	<b>1:143-144;</b> 1:210; 1:225-226; <b>2:12-13;</b> <b>2:41-43;</b> 2:75-76; 2:461-463
<b>Prevalence</b>		
3-4% of mentally ill children	A. "...at the most three to four percent is what I think." B. <i>"...anywhere from 2 to 4...Four being at the high end, but, I would say anywhere from two to four."</i>	1:304-305; <b>1:323-324;</b> <b>2:62-66</b>
Uncommon/Rare		1:299-300; 1:313-314; 1:378
Increases over age 10	"...if you were asking me 10 and over, there would be so many more."	<b>1:334-335</b>
<b>Triggers</b>		
Specific Mental Health Diagnoses	"Right, and the sample diagnoses that we're medicating in suicidal children would be typically, mood disorders, uhm ADHD kids, uhm on the Spectrum kids, and uhm, I have found that I just don't see them – the depressed kids."	<b>1:1063-1065</b>
Specific Mental Health Diagnoses: Psychosis: Paranoia, Hallucinations	A. "He kept talking about this witch he was seeing." B. <i>"...he's also said at a different time that there are two ghosts that live in his head. One's blue and one's white. One tells him to have a tantrum, to not listen, to curse, to be rude to other people. And the other one tells him to hurt himself, continue to have this tantrum, and hurt other people."</i>	1:382-384; 1:410; <b>1:443-448;</b> 1:453; <b>2:108-112</b>
Specific Mental Health Diagnoses: Mood	"A most common one, uh, Mood disorders, you know where we see such severe mood dysregulation."	<b>1:458-459;</b> 1:469-473; <b>2:116-117</b>

Disorders/Dysregulation		
Specific Mental Health Diagnoses: Born Drug Addicted	<i>"He was also born very drug addicted when he was a baby – went through a six month withdrawal period, uhm, from the substance abuse."</i>	<b>2:117-119;</b> <b>2:125-126</b>
Specific Mental Health Diagnoses: Autism Spectrum Disorders		<b>1:517-528</b>
Specific Mental Health Diagnoses: NOT Depression alone.	A. "...I don't see a lot of children who become suicidal as a result of just depression." B. "I mean, we have some depressed children, but the little kids, they're rare. It's not common that I see a kid with real depression and then suicidal intent. Most of our kids are much more agitated than just a withdraw and depression."	<b>1:1001-1002;</b> <b>1:1082-1084</b>
Parental Mental Health Issues	A. "...mood disordered children so often have mood disordered parents. You know, the genetics are there." B. "...her mom is depressed and really unable to monitor and tune in."	<b>1:478-479;</b> <b>1:813-817;</b> <b>2:136-137;</b> <b>2:143-146;</b> <b>2:184-189</b>
Parenting Issues: Inconsistent parenting, genetic inheritance, and poor social modeling lead to children's insecure attachments	"...there's not a lot of structure to the parenting. It's inconsistent, and therefore, the children's attachments are not secure attachments...You know, so if you were to look at attachment issues, so many of those kind of children have at least one parent who they are ambivalently or insecurely attached to because that parent is too unpredictable."	<b>1:483-484;</b> <b>1:497-505</b>
Chaos in home	A. "Parents hate each other. So, lots of chaos going on in this divided couple. And this little girl says she wants to die." (Referring to 7 year old recently discharged from hospital.) B. "And, so I think that for one group of suicidal kids, it's this extremely chaotic, confusing environment....That is, I'd say, permissive for suicidal ideas."	<b>1:551-553;</b> <b>1:599-604;</b> <b>1:609-612;</b> <b>1:633-634;</b> <b>2:135-136</b>
Trauma: Neglect, Abuse, Witnessing Domestic	<i>"Uhm, some of them have it's – they have been neglected and abused and maybe have witnessed, uhm, some type of domestic violence or anger explosions..."</i>	<b>1:623; 2:138-140;</b> <b>2:388-392</b>

Violence, or Traumatic Life Event		
Unknown Triggers		2:82-83; 2:97-101; 2:460-461
Attention-Seeking	<i>"...He just wanted attention. And he wanted to try and get what he wanted at any cost."</i>	2:243; 2:171-177; 2:192-193
<b>Diagnosing Suicidality</b>		
Diagnostic interviewing is used as no reliable child suicide scale is available.	"I don't know what suicide scales are like for kids, okay?"	<b>1:744</b>
Acuteness/Lethality and frequency of behaviors considered	"I mean, we say that these children all have suicidal ideation. But when we're trying to determine which children with suicidal ideation are we most worried about..."	1:753-754; 1:758; <b>1:821-823</b>
Family support considered	"There's a lot of risk. So I guess one of the things I'm so carefully looking at when I'm really assessing "Do I think this child's suicidal ideation is a significant risk?" is what is the support system like? What is the house like? What is the family like? If the family is chaotic, and nobody's going to notice what's going on with this kid..."	1:758-759; <b>1:770-774</b> ; 1:798-799; 1:827-828
<b>Parent/Family Response</b>		
Families react with different levels of support	A. "He's such an unusual kid because we clearly had a mom there who I felt was on target. You know, who was doing what she could to protect him and support him." B. "And so, I felt comfortable, even when he was really self-destructive, allowing him to remain in the house." C. "I think that the moms who are healthy respond extremely well. You know, that they are very devoted to try and keep their children safe. And trying to learn skills to help with the mood dysregulation. So, I see a tremendous amount of good parents, who are willing to learn skills to help their children." D. "So, parents, uhm, I think react in one – partly	<b>1:398-400; 1:874-875; 1:1109-1113; 1:1149-1151; 1:1192-1203; 2:279-280</b>

	due to their own mental health – with a tremendous amount of support, or they just continue in the chaotic, you know, way they've always treated their children."	
Ambivalence to medication	"I see tremendous ambivalence to medication, which I think is reasonable...Because you're putting on children on medications with absolutely so little evidence that they're safe in the long run."	<b>1:1117-1123</b>
Family in denial	A. "Uhm, but families like that where parents have their head in the sand, you know, and they're not really able to monitor the kids." B. "...there's another group of parents who just can't acknowledge that the child can be that severely disturbed." C. "...many parents just go into denial." Example: Child engaged in reckless behavior at school and program, psychiatrist put on medication, mother missed first follow-up appointment. When the psychiatrist called, "...she totally blamed the program and school for his misbehavior and said that at home, he's an angel...And that she never sees this kind of behavior at home, and it's all our mishandling of the child."	<b>1: 812-813; 1:1155-1156; 1:1165-1166; 1:1166-1182; 2:242-253; 2:264-267; 2:272-274</b>
Children are not able to have such feelings	"So, I think we see that really commonly, you know, in another group of people that they just really are unable to see the child as an individual in their own right, who has thoughts and feelings that are very different from what moms or dads would think they should have."	<b>1:1184-1187; 2:294-296</b>
Accessibility to Treatment		

Limited access to child psychiatrists	A. "I think they feel that it's extremely difficult to get services. They can even wait weeks and weeks and there's never access easily to child psychiatrists. Uhm, when you have a severely disturbed child and you need to get to a child psychiatrist, that's a nightmare for parents. So, until there's a crisis, and your child gets seen by a crisis center, and then emergency services are put into place. Uhm, parents who have children who are not going through the crisis system, but who are on their own, in the community...For them, it's a nightmare." B. "There really aren't enough. I mean, it is horrendous."	1:1212-1222; 1266-1270
Crisis services only	"And sometimes what happens when they go into a hospital is it's a dramatic enough shift that it's a crisis. So the crisis services come in that were not able to be put in place before that. You know, without us calling it a "crisis," we don't get the services."	1:832-835; 1:844; 2:442-443
Treatment Not Well Known in Community	<i>"I think there are a lot of different programs...and I think they're all readily available. But, what I don't think is helpful, is that...uhm...unless you're in a specific agency, your social service area, you really don't know that these places are available to you. And, you may not know that you have the resources available to help you and your child..."</i>	2:420-425
<b>Treatment Methods</b>		
Psychoeducation to Increase skills: Coping, Communication, Self-calming, Breathing, Impulse control	"They should have a program like us to really teach her coping skills and the ability to better communicate her needs and feelings." (Needs of one 7 year old child)	1:589-591; 1:655-668
Counseling	A. "...they really need in-home counseling to try to help the parents better understand their effects on this poor child." B. <i>"I definitely feel that they should be in some kind of counseling or therapy."</i>	1:592-593; 2:311-312; 2:420-421
Counseling: Cognitive	Trauma-focused CBT; "I Can Problem Solve" curriculum for preschool children.	1:623-624; 1:643-645;

Behavioral Therapy		2:160-171; 2:336-357
Counseling: Traditional Talk Therapy	A. "...first you really want to try to get to the bottom of what they truly mean when they say, "I want to kill myself, I want to hurt myself, I want to rip my head off." Uh, we try and ask them questions, we try to get them to tell us how they're feeling – why they would say something like that." B. "And then, just talk to them and ask them lots of questions. Because, uhm, I think it's really hard when you're working with three, four, and five year-olds to, kind of, do any other thing."	2:156-159; 2:182; 2:189-192; 2:199-200; 2:216-218; 2:312-314
Hospitalization/ Crisis Center	A. Minimal interventions, but a break from the family/chaotic environment. "...how does an environment like Kennedy help a little girl like her? I think it just gives her a break from the chaos." B. "So, is there anything that we can do? No. But what we can do is take children out of the chaotic family to give them a little bit of you know, a distance. So that they can, uhm...so that they can sort of use that time to talk with themselves." Hospitals are understaffed. C. "I think it depends on the child and the severity of how often they say this. Uhm, if they've actually attempted intentionally or not intentionally to hurt themselves. Uhm, sometimes I do think they need to be hospitalized right away."	1:650-651; 1:672-679; 1:707-708; 2:233-234; 2:322-324; 2:421
Collaboration with family required	"I feel we should be able to handle it, but the problem is whether we have a household that is able to handle it, as well."	1:863-864
Out of home placement	A. "And that most kids, uhm, most kids they...trauma of the separation is very significant. And, so I really see residential treatment for young children as a last resort." B. "And most of the kids I've seen who have been through that, uhm, are very – you know, it's something they talk about a lot. How sad they were, how hard it was for them. It was a really awful experience."	1:907-909; 1:913-915

Psychiatry/ Medication	A. "We're never medicating suicidality. We're always just medicating an underlying diagnostic condition." Abilify for Mood Disorders; Intuniv for ADHD/impulsivity; Atypical Antipsychotics for Autistic children with rage. Most popular are: Abilify, Risperdal, Seroquel. B. "I like Abilify because Risperdal raises prolactin levels. And Seroquel doesn't have approval on children." C. Side effects from medication: Flat affect: "I always think of it like this: he was in color before, and now he's in black and white."	<b>1:938-940;</b> 1:948; 1:1007-1008; 1:1017-1021; <b>1:1031-1032; 1:995-996;</b> 2:228-229
Psychiatry/ Medication: Telepsychiatry as hospital	Refers to lack of adequate staffing in hospital crisis centers: "So, the ten year old was supposed to talk to the psychiatrist on a screen. Yeah, and the whole thing was so incredibly frustrating, and I don't think at all therapeutic."	<b>1:700-702</b>
Physically Remove Child From Harm		2:200-208; 2:213-214
Emotional Support & Providing Age- Appropriate Boundaries: Building Trust by creating a safe environment, providing structure, and treating children differently than adults.	<i>Console them. "You really have to work hard and show them that you're there for them, that they can trust you. Uhm, no matter what they say or do to your, or anybody else, you're still going to be there for them. You're not going to leave them, like previous experiences they've had. You're not going to hurt them. You're just going to be there, you're going to love them, you're going to give them structure, discipline, consequences, and that's how you really start to build these relationships."</i>	2:210; <b>2:381-398</b>
Individualized Treatment	<i>"...when we're working with kids and their problems, it's very much on an individual level because not everybody feels the same all the time, not everyone sees the problem the same way, not everybody comes up with the same exact solutions to solve these problems."</i>	<b>2:370-373</b>
School Interventions/ Response		

Prevention	"Well, I think particularly in the lower grades, uhm, I don't think that they do much in the lower grades with the children."	<b>1:851-852</b>
Managing Crisis	"And as soon as they get any inkling that a child has any kind of self-destructive urges, they're out of school, as you know... They just don't see it as something that's in their domain."	<b>1:852-857</b>

Appendix B-1. *Participant Profiles.*

<b>Code Name</b>	<b>Cultural Identity</b>	<b>Professional Identity</b>	<b>Degree and License(s) Held</b>	<b>Number of Suicidal Children Served</b>	<b>Years Serving Suicidal Children</b>	<b>Type of Suicidality Addressed</b>
P001	Caucasian male	Social worker at community mental health agency	MSW, LSW	A few (2-3)	2-3 years	Ideation, Behaviors, Attempts
P002	Caucasian female	Counselor at community mental health agency	MA	Several (4-5)	4-5 years	Ideation, Behaviors, Attempts
P003	Caucasian female	Direct care provider at community mental health agency	MA	Many (6-10)	4-5 years	Ideation, Behaviors
P004	Caucasian female	Child Psychiatrist at community mental health agency	DO, Board Certified in General Psychiatry	More than 10 (11+)	4-5 years	Ideation, Behaviors, Attempts
P005	Caucasian male	Counselor at community mental health agency	PhD, LPC	Several (4-5)	17 years	Ideation, Behaviors, Attempts
P006	Caucasian female	Counselor at community mental health agency	MA, Child Psych Nursing, LANCC	More than 10 (11+)	35 years	Ideation, Behaviors, Attempts, Completed Suicides

P007	Caucasian female	School Counselor, Elementary setting	MA, LAC, NCC	Several (4-5)	2-3 years	Ideation, Behaviors, Attempts
P008	Caucasian female	School Counselor, Elementary setting	MA, NCC, Certified in Student Personnel Services; Elementary Teacher K-8	More than 10 (11+)	2-3 years	Ideation, Behaviors, Attempts
P009	Multiracial female	Former Counselor at community mental health agency	MA	Several (4-5)	10 years	Ideation, Behaviors
P010	African American male	Direct care provider at community mental health agency	MSW	Several (4-5)	12 years	Ideation, Behaviors, Attempts
P011	Caucasian female	Counselor supervisor at community mental health agency	MA, LPC, ACS	More than 10 (11+)	10 years	Ideation, Behaviors, Attempts
P012	Caucasian female	Counselor at community mental health agency	MS	A few (2-3)	1 year	Ideation, Behaviors, Attempts

Appendix B-2. *Children's Treatment Chart Profiles.*

Code Name	Age of Onset	Cultural Identity	Suicidal Ideation Present	Suicidal Verbalization Present	Suicidal Behavior Present	Suicidal Attempt Present
C001	5 years	African American male	Frequent	Frequent	Frequent	3 or more attempts
C002	3 years	African American male	Infrequent	Infrequent	Frequent	No.
C003	5 years	African American male	No.	Frequent	Frequent	No.
C004	4 years	African American male	Infrequent	Infrequent	Infrequent	No.
C005	4 years	African American female	Infrequent	No.	Frequent	No.
C006	4 years	Multiracial male	Intermittent	Intermittent	Very Frequent	No.
C007	7 years	Caucasian male	Intermittent	Intermittent	Infrequent	No.
C008	7 years	Caucasian female	Very Infrequent	Infrequent	Intermittent	1 attempt
C009	7 years	Caucasian male	Intermittent	Frequent	Intermittent	No.
C010	4 years	Caucasian male	Intermittent	Intermittent	Intermittent	Unknown #.
C011	6 years	Caucasian male	Frequent	Intermittent	Very Frequent	1 attempt
C012	Unknown	African American female	Frequent	Intermittent	Intermittent	No.
C013	9 years	African American male	No.	Intermittent	No.	2 attempts
C014	6 years	Multiracial male	No.	Very Infrequent	Infrequent	No.
C015	9 years	African American male	Frequent	Intermittent	No.	No.
C016	3 years	Caucasian male	Infrequent	Intermittent	Intermittent	No.
C017	7 years	Caucasian male	Infrequent	Infrequent	Infrequent	1 attempt
C018	3 years	Caucasian female	Infrequent	Infrequent	Very Infrequent	1 attempt
C019	9 years	Caucasian male	Infrequent	Intermittent	Infrequent	No.
C020	6 years	Hispanic male	Intermittent	Infrequent	Infrequent	No.
C021	7 years	African American female	Infrequent	Intermittent	Infrequent	No.
C022	6 years	Caucasian male	Intermittent	No.	No.	No.

## VITAE

Katherine Angela Heimsch earned a Bachelor's degree in Psychology from Rider University in 2004. Shortly after, she began working with children with behavioral and emotional issues. Desiring a deeper understanding of mental health issues, Ms. Heimsch returned to Rider University to study counseling. She earned both Master's and Educational Specialist degrees in Counseling Services with a concentration in community mental health in 2009 and 2010, respectively, and graduated with honors.

While working in the field children's mental health in New Jersey and Colorado, Ms. Heimsch noticed gaps in services for children with some of the most severe challenges, especially suicidality. She began her doctoral work at Old Dominion University (ODU) in 2011 with the aim of becoming an advanced practitioner and supervisor. During her time at ODU, Ms. Heimsch served as a director for the counseling department's student training clinic at the Norfolk Community Services Board, and worked as a teaching assistant in the human services department. In 2013, she was awarded with the National Board for Certified Counselors (NBCC) Minority Fellowship, and in 2014, she was named ODU's Outstanding Doctoral Student in Counseling.

Ms. Heimsch is currently a Licensed Associate Counselor in the State of New Jersey, and holds the National Certified Counselor and Approved Clinical Supervisor credentials. She has presented regionally and nationally on counseling topics such as: multiculturalism in supervision, diagnosis, and adolescent substance abuse. Ms. Heimsch continues to work as a clinical mental health counselor, and volunteers for the profession as a reviewer and mentor for NBCC, and a site supervisor in collaboration with The College of New Jersey.