It is a tribute to this family's courage and resilience

My name is Moshe, I am a psychologist and a family therapist.

Twenty years ago I worked in a child psychiatric clinic. Many of the children I saw were school refusers. I spent a lot of time talking to them and became aware of how unhappy they were. I tried to draw attention to their unhappiness. A colleague and I compared all severe and longstanding school refusers in Melbourne with regular school attenders from the same class, of the same sex, and closest in age. Our clinical impressions were confirmed: the school refusers were more depressed, had more psychosomatic complaints (such as headaches, stomach pains), sleeping problems, separation difficulties and disruption in their family life. As there was no way to measure childhood depression we developed a scale.

This scale was published by the Australian Council of Educational Research as 'The Children's Depression Scale'. On the basis of clinical experience and a literature review, sixty-six statements describing the child's thoughts and feelings, forty-eight negative and eighteen positive, were selected. Each statement was printed on a separate card and the child asked to put the card into the appropriate box. Boxes were labelled—'very right', 'right', 'not sure/don't know', 'wrong', 'very wrong'.

The statements included:

Sometimes I wish I were dead.
Often I feel miserable or weepy or unhappy.
Often I feel lonely.
I often imagine myself hurt or killed.
Often I hate myself.
I feel tired most of the time when I am at school.
Often I feel as if I am letting my mother or father down.
I get fun out of the things I do.
Often I enjoy myself at school.
Many people care about me a lot.

Publication Reference:
Lang, M. (1986) It is a Tribute to this Family's Courage and Resilience. In S. Fabian, The Last Taboo: Suicide and Attempted Suicide Among Children and Adolescents (pp. 183-190). Australia: Penguin Books.

The statements were also reworded and given to the parents and other adults who knew the child, such as the teacher, to get an independent assessment of the child.

The scale has been widely used since 1978 in Australia and other countries. Evidence has accumulated supporting its reliability and validity. Users agree that the children like the scale and its gamelike quality. They find it helpful in communicating their thoughts and feelings. The fact that children are able to communicate their unhappiness so directly clearly suggests that failure to do so in the past may be a reflection of adults' reluctance to enquire rather than the children's inability to tell.

Why this reluctance? It is commonly believed that talking about unhappiness makes it worse—so people say, 'Cheer up, look on the bright side.' There is a fear that inviting the child to talk would reinforce the misery rather than relieve it.

However, it is found that enabling the child to talk is often helpful.

There is a common belief that childhood is a time of fun and happiness. Enquiring may explode this myth.

Parents are unable to enquire because they feel responsible and guilty, so their only way to cope is by denial. Often parents of a depressed child are themselves depressed, feel pessimistic, have little energy and resources and are unable to see a way out of their own life predicament. If they did find their child depressed they would be unable to help and this would further confirm their own feelings of failure and impotence.

All children from time to time are miserable or weepy, have a negative self-concept, and feel lonely. This is part of life. However, when it affects the child's general functioning, (such as schoolwork, health, friendships), when it is longstanding, intense, and persists without apparent reason, then professional help may be required.

Certain family patterns may lead to the development and/or maintenance of depression in the child. A family's tendency to avoid acknowledging painful experiences and personal conflicts

reduces the likelihood of being able to clarify and resolve difficulties. This pattern is often developed to protect family members, to make them feel comfortable. Unfortunately, in spite of such good intentions, this denial leads to depression and ensures its maintenance.

An example of this tendency is when parents have marital tensions and conflicts and are unable to confront them directly. They often do it through the child who is then the meat in the sandwich, the go-between. The child is burdened by the parents' hostility, unhappiness and complaints about each other. The child is the recipient of their problems and is unable to off-load the burden. The responsibility to maintain the marital relationship also, to a certain extent, becomes that of the child. Thus, she or he becomes the residual family therapist, an individual counsellor for the parents, and often is called upon to perform a parent-like function, not only in relation to the parents, but also to the brothers and sisters.

Such a role is in some ways seductively attractive, the child becomes central and powerful in the family. Yet the demands of this role are well beyond his or her experience and there is no opportunity to be 'child-like', 'carefree'. This role has within it the seeds of its own destruction: the child is unable to offer proper help to parents and siblings, thus failure is inevitable and with it feelings of inadequacy, inferiority and guilt.

Sometimes the child is in coalition with one parent against the other. In this situation the burden of trying to understand and comfort the favoured parent and at the same time be subject to resentment, hostility and jealousy from the other parent becomes unbearable.

Though the child is central and important she or he also feels exploited and neglected. This is because the child's own wishes and needs are not recognised and attended to. Often this child, apart from missing out on love and care, is not provided with appropriate limits, firmness and guidance.

The child's failure to tell the parents his or her worries is understandable. She or he feels the parents do not wish to hear or are incapable of hearing his or her distress.

The parents of depressed children are not 'bad' parents. This is too simplistic. Often they are caught up in similar problems in their own families of origin. The tradition is continued from one generation to the next, being caught up by their loyalties and obligations and because they have never known any better. Each individual in such families may engage in attempts to break this problem and bring about a positive change but unintentionally the behaviour of the others frustrates this attempt.

These problems provide the social context for understanding suicide in children and adolescents. Whilst it is most unfortunate that a child would attempt suicide, for hopefully there are other ways in which a child can express the wish for change in the family, yet it can be seen as a very positive statement. The child is saying she or he is neither able nor willing to continue with the way things are, the family and also the child need to change. Unless such change takes place, death is preferable; life under the present circumstances is not worth living.

It is a powerful statement in that it may shift the focus from the family's internal and private suffering into the public domain. It is brought to the notice of others, thus helping professionals have the opportunity to intervene. Seen in this light, the suicide attempt is not just a threat, but a challenge and an opportunity to provide the stimulus for change.

It is tragic if such a suicide attempt is seen purely as a medical emergency: the child's stomach is pumped out after an overdose, or a blood transfusion replaces blood lost after the wrists were cut, and the child is sent home. Equally tragic is the tendency to treat the suicide attempt as evidence of the child's own abnormality, individual psychopathology, or as some biochemical imbalance.

Seeing the problem as residing purely in the child could lead

to further confirmation of the child's inadequacy and guilt, and again to the denial of the real problem which led to the suicide attempt in the first place. The child is then further isolated, becomes more depressed, feels there is no way out of the predicament and no help will be forthcoming. The next attempt is more likely to be successful.

I see a lot of child and adolescent suicide attempts in my practice. This week I saw a number of new families and in two of them the major issue was a series of overdoses by young people in the family. In one family a daughter was caught up in interpersonal conflict. She was nineteen years old and a very good girl, the perfect daughter. According to father they had a close relationship. She was the youngest, the other children had left. She was doing nursing and was about to graduate. She fell in love with a young man but the father disapproved of him. Life became unbearable for her. She had always been a good girl who had always listened to her father, she couldn't handle the conflict. She became depressed. She was taken to a psychiatrist who gave her medication but hardly talked to her. She returned home and shortly afterwards took an overdose. She was taken to hospital, given some more medication, later ECT, now she has had a few years of a psychiatric 'career'. Until now, hardly anybody has ever talked to her about her life.

For the suicide attempt not to be wasted, but to be as helpful as possible, it needs to be recognised as a powerful statement saying the social situation, of which the child is an integral part, needs to change.

When such a statement is heeded there is ground for optimism. A skilful family therapist, who is willing to give time and attention and listen with care to the family's unhappiness, despair and conflict, is in a good position to help the family to change. However, to sit and listen to the depth of their depression is no picnic.

All members of the family sit with the therapist and each is invited to say how each perceives the problems in the family.

Possibly for the first time each has listened to the others. Having listened to every person, the therapist would note the way the different family members relate and interact with each other.

The therapist would ask the family what solutions they have tried, and may then explore new solutions.

On the whole, the public is unaware of the problems we have been talking about. I became interested in childhood depression in 1965. When I talk about it publicly lots of adults approach me afterwards and say, 'Thanks for talking about it, I thought I was the only one'. They have often told me that they had attempted suicide and never told anyone about it. It's horrifying how common it is.

Sometimes I like to use positive terms to describe this conspiracy of silence. There is a wish to deny something that is harmful and destructive. The fact that no one talks about it is a way of protecting and showing love and loyalty. Kids don't want to hurt their parents by telling them of their unhappiness and their thoughts of death and suicide.

Often they know it would be too painful. Maybe they're right, maybe their parents couldn't cope with it. There's a lot of talking to do and a lot of painful stuff to be dealt with and sometimes it gets too much and people run away from it. It's not easy. The suicide attempt is just the tip of the iceberg, just an expression of a lot of pain and a process that has been going on for a long time.

Often people do family therapy without knowing it. 'Family therapy' has a number of meanings but basically it's a way of thinking. What it means is that when a child tries to kill him or herself you don't start asking, 'What's wrong with this kid?' You don't try to find an answer in his or her behaviour, health or biochemistry. You would be looking for an answer that is embedded in the social system in which the kid lives. It's widening the frame. It looks at an individual as part of a larger group. Then there are other issues that affect the family, like societal attitudes and global problems. In searching for an answer and an understanding of the problem, the practical

implications are inordinate. It assumes that there isn't a single individual who is to blame or to be faulted.

There are many people such as nurses, police, ministers and teachers who deal with families. They work at the front line, often encountering the problems when the distress and anger is at its highest. It is the policeman who is called in the middle of the night to deal with domestic violence. The teacher may be the first to notice a child's inability to concentrate, his or her social isolation and misery. If they became familiar with family therapy, its ideas and techniques, perhaps they and the families would be better off.

Some years ago I saw a family in which Donna, fourteen and a half, and her mother made suicide attempts at different times. Donna felt her parents never talked to each other directly, only through her. They put all their pressures on her, and she was burdened by this 'go-between' position. At the same time she felt neglected and as if she were not part of the family.

After hearing each member's statement, it was suggested that the parents co-operate and work together as parents. Unexpectedly, Donna protested when her parents started to impose appropriate limits on her behaviour. After a short struggle she accepted the limits and benefited from them.

At first Donna and her mother were over-involved. She was about to sever all relationships with her father. After weeks of hard work and struggle they sorted things out and re-established a co-operative and loving relationship.

This description makes therapy appear simple, but this is far from the truth. The situation was complex and highly charged with sadness and anger. They would not have resolved their problems without a hard struggle entailing pain and commitment. The full story of this family was written by a colleague and myself and published in a series of five articles in the *Australian Journal of Family Therapy* under the title 'Blackmail is Against the Law'.

It gives a very detailed and vivid account of the circumstances leading to a suicide attempt by a young girl. It is also a statement

of hope: that lifelong, destructive behaviour problems can be changed for the better. It is a tribute to this family's courage and resilience.

I can't stop the trend but I can help individuals feel happier on their islands

My name is Murray. I'm a doctor, a general practitioner. I have a practice in the inner suburbs.

Nowadays kids know more about methods of suicide and have ready access to them. They no longer accept that suicide is wrong. Kids nowadays make more serious decisions than a decade ago.

There are more girls attempting suicide but it's difficult to determine how seriously they want to die. Boys are not as vocal, they are gory. Girls are clean.

When an overdose occurs the doctor's role is easy. Time often solves problems more than the treatment. Drugs can help in a significant number of cases, but kids often overdose on prescribed drugs. There haven't been many actual suicides in my practice. Up to a third of all kids are depressed when they are being treated. The support of the doctor is important. Mostly it's a case of counselling the individual. I sometimes send them for family counselling. The doctor tries to set up a good relationship so that they feel they are loved.

Kids do as little as possible to support themselves financially. Money is not necessary because hire purchase is possible; they don't budget; they can get housing; they don't cook for themselves; they smoke, have a good time, go out. They may be without a job for a long time. Many think that a job is not worth while and it's possible to be on the dole. Nothing is worth achieving. They've got everything they need. Family life is going out of fashion. Girls have children for independence from their parents not for a relationship.