Child and adolescent suicide : Facts, assessment and preventive strategies

Subir Bhattacharjee
Assistant Professor, Department of Psychiatry, PGMCH, Purulia

Suicide, act of killing oneself or self murder, is the 10th leading cause of death worldwide.[1] It resulted in 828,000 global deaths in the year 2015 with an increase from 712,000 deaths in 1990.[2] Important factors, affecting suicide, include psychiatric disorders, drug use, cultural, family and social situations, psychological states, and genetics.[3] Half of all adult suicide was found to have diagnosable major psychiatric disorder. Major depressive disorder, bipolar mood disorder increase the risk of suicide by 20-fold.[4] Other disorders include schizophrenia (14%), personality disorders (8%), obsessive compulsive disorder, and posttraumatic stress disorder.[5]

Though it was previously assumed that suicide is rare in children and in adolescent, but recent data[6] is showing that it is no more uncommon and becoming more frequent with increasing age. Suicide is now the sixth leading cause of death for 5- to 14-year-olds. Among them, latest mean worldwide annual rates of suicide were 0.5 for females and 0.9 for males per 100,000 population and those for 15–24-year-olds were 12.0 for females and 14.2 for males per 100,000 respectively. Male suicide rate is found more than female adolescent population from most of the countries. But females were observed to attempt suicide 3 times as often as males.

Unfortunately less than half of those young people who have attempted suicide had received psychiatric care. It points towards need of broad prevention strategies in healthcare and social services. This article reviewed on recent advances in child and adolescent suicide, how to understand suicidal behavior in them and what the preventive strategies are.

Corresponding Author :
Subir Bhattacharjee
Assistant Professor, Department of Psychiatry
PGMCH, Purulia

CHILDHOOD AND ADOLESCENT SUICIDE : SIMILARITY AND DIFFERENCE?

Two different groups exist to define suicide under 15 years, child suicide group that of 5-11 years of age and adolescent suicide group that of 12-14 years age. Researchers[7] found similarity in characteristics and pattern between these two groups. They found that both groups had significantly more boys than girls. 85% of child suicide group and 70% that of young adolescents group were male and most common method of suicide were hanging/strangulation/suffocation (64% of the young adolescents and 81% of the children). Firearm was the next most common method of suicide in both groups (14% of children, 30% of young adolescents). Almost all of the deaths occurred at home (88% of the young adolescents and 98% of the child suicide) and the timing of suicide attempt was between the hours of noon and midnight (81% of children and 77% of young adolescent's suicide). In both groups, most common problem was relationship problems that was found to linked to suicide (60% of the child suicide and 46% of the young adolescent suicide). They had relationship problems with friends or family members. Other common problems were school problems and recent crises (30-40% of cases for both children and adolescents group).

Differences were found too for these two groups. Suicidal death was found more in black child group (37%) than their adolescent group (12%). But overall

suicide was more in white than black child group. Again there was increase in suicide in black children (1.36 to 2.54 per million) whereas suicide rate in white children (1.14 to 0.77 per million) was decreased, found by the scientists from The Research Institute at Nationwide Children's Hospital in two four-year time periods, starting in 1993, and in 2008.[7]

CHILDHOOD AND ADOLESCENT SUICIDE : WHAT ARE CAUSES?

Diagnosable psychiatric disorder was found in one third population of both groups. Whereas Attention Deficit Disorder (59%) was found twice as common than depression or mood disorder (33%) in child suicide group, among the adolescent group, depression (66%) was about twice commoner than ADHD (29%).[7]

Suicide intent was not prominently found in child and adolescent suicide and they were not very much preoccupied with suicide and craving to end their life. Researchers found that rather desire for acceptance, recognition, control, empathy, validation, and prompt resolution of interpersonal conflict and responsiveness were key to the suicide attempt in child and adolescent group. Depending on suicide intention and premorbid behavior, it was observed that few feels depressed, helpless, hopeless, worthless, and were unable to enjoy themselves and rest were more impulsive, aggressive, irritable, disruptive, and attention-seeking in their behavioral pattern. Impulsive behavioral pattern was more commonly found in child suicide.[8]

It was observed that at least in some cases, children felt extremely distressed in stressful life interaction but don't know how to cope those situation and then impulsively attempted suicide, but not really expecting to end their life.[9]

WHO ARE PRONE TO SUICIDE?

According to American Academy of Child and Adolescent Psychiatry, though suicidal thoughts and attempts are often associated with depression, there are other recognizable risk factors of child and adolescent suicide. Those risk factors are listed in table-1.

Table-1: Risk factors for child and adolescent suicide.

1. Feelings of hopelessness or helplessness
2. Family history of suicide attempts
3. Aggressive or disruptive behavior
4. Access to firearms
5. Exposure to violence
6. Impulsivity
7. Acute loss or rejection
8. Bullying
9. Poor coping skills

CHILDHOOD AND ADOLESCENT SUICIDE : PROTECTIVE FACTORS

In opposite to the risk factors, there are protective factors too for child and adolescent suicide.[10,11] Those protective factors are listed upon in table-2.

Table-2 : List of protective factors of child and adolescent suicide

1. Positive Relationships (family, extended family)
2. Solid family cohesion and supports
3. Good problem solving and coping skills
4. Engagement in extracurricular activities
5. Involvement in faith/religious communities
6. Strong connections to school
7. Supportive teachers and parents
8. Positive self-esteem

CHILDHOOD AND ADOLESCENT SUICIDE: WARNING SIGNS?

Children and adolescents who are having suicidal thoughts may speak out suicidal statements or comments openly such as, "I won't be a problem for you much longer.", "Everyone would be better off without me." or "I wish I was dead,". Researchers and associations[10,11] recommended for warning signs of suicide in child and adolescent people and one must be careful of those warning signs. The more warning signs a child expressed, the higher the risk of suicide attempt and completion. If ones child expresses suicidal thoughts or exhibits self-harming behaviors or shows those warning signs, immediately seek professional help.

Table-3 : List of warning signs of child and adolescent suicide

1. Increased irritability
2. Changes in appetite
3. Preoccupation with death
4. Intense sadness and/or hopelessness
5. Not caring about activities that used to matter
6. Social withdrawal from family, friends, sports, social activities
7. Substance abuse
8. Risky behavior
9. Lack of energy
10. Inability to think clearly/concentration problems
11. Declining school performance/increased absences from school
12. Sleep disturbance (either not sleeping or staying awake all night)
13. Giving away possessions

HOW CAN ONE COMMUNICATE AND PREVENT?

Talking about suicide may not be an easy and comfortable thing at first, but once the ice is broken with little courage and initiative, it will be much fruitful for the most needed. Simply asking child or adolescent whether he or she is depressed or having suicidal thoughts can be very much helpful. Just ask those following direct and non-judgmental questions with assurance -

I'm worried about you, -

Q. Have you ever thought about hurting or killing yourself?

Q. Are you feeling sad or depressed?

Q. Are you thinking about hurting or killing yourself?

One may fear that those questions may intrude thoughts of suicide. On the contrary it is found to provide assurance to them and will give the needed child a space to talk about his or her problems. Regardless of one's response, if someone suspect that his/her child may be suicidal, ask for immediate help from psychiatric professionals.

School is another area where detection of these at-risk children can be improved. Teachers, support staff, and school counsellors can play a significant role in early recognition of suicidal behavior in children.

With the right and timely measures, a child will have full recovery from suicidal thoughts and behavior and may live a happy life and may overcome future similar problems. Always encourage your child not to isolate him or herself from family and friends.

CONFLICT OF INTEREST-NONE

REFERENCES

1. Värnik P. "Suicide in the world". International Journal of Environmental Research and Public Health, 2012; 9 (3): 760–71.

2. GBD 2013 Mortality and Causes of Death Collaborators. "Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013 : a systematic analysis for the Global Burden of Disease Study 2013". Lancet, 2015; 385 (9963): 117–71.

3. Hawton K, Saunders KE, O'Connor RC. "Self-harm and suicide in adolescents". Lancet, June 2012; 379 (9834): 2373–82.

4. Kutcher S, Chehil S. Suicide Risk Management A Manual for Health Professionals (2nd ed.). Chicester: John Wiley & Sons., 2012:30–33.

5. Bertolote JM, Fleischmann A, De Leo D, Wasserman D. "Psychiatric diagnoses and suicide: revisiting the evidence". Crisis, 2004; 25 (4): 147–55.

6. Pelkonen, M. & Marttunen, M. Child and Adolescent Suicide-Epidemiology, Risk Factors, and Approaches to Prevention. Pediatr-Drugs, 2003; 5: 243.

7. Sheftall, A.H., Asti L, Horowitz LM, Felts, A., Fontanella, C. A., Campo, J. V., & Bridge, J. A. Suicide in Elementary School-Aged Children and Early Adolescents. Pediatrics, 2016; 138.

8. Anderson, A. R., Keyes, G. M., & Jobes, D. A. Understanding and treating suicidal risk in young children. Practice Innovations, 2016; 1:3-19.

9. Bridge JA, Asti L, Horowitz LM, et al. Suicide trends among elementary school-aged children in the United States from 1993 to 2012. JAMA Pediatr. 2015; 169(7):673–677.

10. Tishler, C., Reiss, N. and Rhodes, A. Suicidal behavior in children younger than twelve: A diagnostic challenge for emergency department personnel. Academic Emergency Medicine, 2007; 14(9):810-818.

11. Bridges, L. and Murji, R. Tattered Teddies: An interactive handbook about the awareness and prevention of suicide in children. Calgary: Centre for Suicide Prevention, 2008.