Child and Adolescent Suicide

by Ernest J. Bordini, Ph.D.
Clinical Psychology Associates of North Central Florida, P.A.

Reprinted with permission from GAINESVILLE FAMILY MAGAZINE
All Rights Reserved

The topic of suicide in children and adolescents is a difficult one since there is possibly no loss greater than that of a child. It is therefore all the more alarming that along with individuals over the age of 65, children and adolescents have suffered increased suicide rates over recent years. With respect to the rate of suicides, adolescent suicide has increased 300-400% over the past ten years. Suicide accounts for 2% of all deaths in the U.S. but 15% of adolescent deaths. That means approximately 2000 adolescents commit suicide each year. Relative to other Southern states, Florida tends to have a higher than average suicide rate, a statistic that is also complicated by Florida's relatively low rate of adequate health insurance coverage and relatively high rate of alcohol consumption.

Suicide attempts are approximately seven times more common than completed events. As with adults the vast majority (75-90%) of all adolescent suicide attempts were by drug overdose. Also as with adults females account for 75% of the attempts, while males account for 75% of actual suicides. Approximately two of three High School students have had some degree of suicidal ideation. Approximately only one in ten adolescents will make at least one attempt.

While many studies have provided us with a wealth of statistical data, and while clinical psychologists and other mental health providers see many individuals in suicidal crisis, completed suicide remains difficult to predict due to the fact that it remains a relatively rare event (approximately 30,000 per year in the U.S.) in the larger context of the many people considered to be at risk. Many of the factors used as general suicide predictors are factors which would raise concern about the child or adolescent in a broader psychological context.

Due to the difficulty in predicting suicide and the greater frequency of attempts it is critical that parents, professionals and those often-invisible HMO care reviewers realize that any suicidal behavior independent of its lethality places a person at 10-100 times normal rate of suicide risk. Medical personal and parents of children with chronic illness should note that as has been found with adults, chronic physical illness is an important variable in the background of adolescent suicide attempters.

While most psychologists and other professionals agree that predicting suicide is difficulty, many agree that depression of all subtypes and the emergence of helplessness and hopelessness are associated with increased risk. As with much behavior, the best predictor is the past. Previous history of attempts, communication of intent and significant negative life events are particularly important. Persisting suicidal ideation even for a few days warrants attention. Particular concern arises when coping skills become

overwhelmed, there is a loss or withdrawal from sources of support, and thinking becomes irrational or very rigid.

Many people can easily understand that depression may carry an increased suicide risk. While studies have estimated that 83% of suicides were depressed, it is equally important to remember that the majority of depressed adolescents and adults are not suicidal.

Parents and even physicians and other professionals may tend to underestimate the risk posed by otherwise very impulsive children or adolescents with more general adjustment difficulties and a history of risk-taking behavior. Since many suicidal acts are impulsive, adolescents may tend to use whatever means are easily available. Parents with concerns about a depressed or suicidal child or teen should secure or remove firearms from the home, and lock medication and hazardous substances.

Psychologists and other mental health professionals are aware that there may be high risk times in which individuals with elevated suicide risk should be more closely monitored. These involve times where there are significant losses. For children and adolescents these could involve loss of a family member, close friend, parental divorce, a breakup of an amorous relationship, or moves to different schools or homes. Psychological events and real or imagined failures which involve embarrassment, shame or humiliation must also be attended to.

Psychologists and others have studied several risk factors for suicide in adolescents and young adults.

Acute or chronic alcohol or drug abuse is associated with elevated risk. Some have reported that approximately a third of adolescents who commit suicide are intoxicated at the time. Parental alcohol or substance abuse problems has also been demonstrated to be a factor in at-risk children and adolescents.

Certain psychiatric disorders such as mood disorders, schizophrenia and Borderline Personality Disorder have been associated with increased risk. Children and adolescents with aggressive or impulsive patterns of behavior or with conduct disorders are at risk. Family psychiatric disorders are also relevant. Emotional states associated with adolescent suicide include depression, hopelessness and anger. These are associated with psychiatric admission, future attempts, and more distress.

History of family problems and family violence is often found in the histories of suicidal adolescents. Abused children have higher rates even when compared to neglected children. Sexual abuse has also been noted in the history adolescents seen in hospital emergency rooms for suicide attempts.

Death of a family member has long been associated with grief and depression. Recent deaths of family members or other psychologically important individuals also place children and adolescents at risk. Psychological losses or separations such as those caused by divorce, changes in school, or moves can also be contributors.

Impaired social skills and impaired peer relationships are associated with suicidal adolescents. Though a substantial proportion psychiatrically hospitalized adolescents having made suicide attempts may describe themselves as loners, studies concerning peer relationships has not always found a consistent relationship.

Being the friend or family member of a suicide victim places individuals at particularly high risk. Adolescent attempters are more likely those with ideation or and non-suicidal students to know another peer who had attempted suicide. This has prompted many schools to pro-actively conduct crisis management sessions and screening when a student commits suicide. Copy-cat suicides are not a new phenomenon and increased rates of suicide have sometimes been associated with publicized suicides.

As with much of behavior in general, the best single predictor is a previous suicide attempt. Estimates have suggested that as many as 40% of adolescents making a prior attempt will try again. Even more alarming is that one of 20 individuals with a history of more than one attempt will succeed in a suicide attempt. Repeat attempters are likely to have had school difficulties, serious life stressors as well as elevated levels of anger and depression. Older adolescent males with chronic conduct problems and poor impulse control make up a large proportion of these repeat attempters.

Humiliation and frustration suffered by some adolescents struggling with conflicts about their sexual development or orientation may sometimes precipitate suicidal behavior.

Short term predictors often involve experiences that are experienced as shameful or humiliating by the child or adolescent. Arrests, perceived failures at school or work, rejection, interpersonal conflict with a romantic partner, or conflict with a parent are common experiences that can sometimes trigger distress and attempts. It is largely agreed upon that the emergence of hopelessness often precedes attempts.

Ready access to lethal means is particularly associated with completed attempts. Only approximately one of four suicides demonstrate any significant prior planning. This means reducing access to lethal means is very important particularly when there is a child or adolescent identified to be otherwise at risk in the home. Medications used are usually those easily found in the home. The rate of suicide by firearms since 1950 has increased three times faster than other methods.

Psychologists have studied the thinking patterns of at-risk adolescents. Difficulties in problem solving, general impulsiveness, negative expectation about rewards and consequence, a persistent negative self-image, treating oneself as an object, and hopelessness are some of the characteristics that have been described.

It is important to note that 80% of attempts and completions are preceded by warning. Though the majority of threats are not followed by attempt parents and professionals must take warnings seriously. Sometimes the only warning is given to peers. Adolescents should be encouraged to report warnings.

Unfortunately, it is likely only half of all adolescent suicide attempters receive any form of psychotherapy.

Sometimes, parental lack of cooperation or denial of the seriousness of the attempts serve as obstacles to adolescents receiving appropriate treatment. Parental attitudes about receiving psychological or mental health assistance and family background often determine which children get opportunities for help. Research has indicated that compliance with follow-up improves when appointments are made for the adolescent or family with a specific provider as opposed to simply giving the caller a name and telephone number.

Dissatisfaction with previous psychiatric treatment, complicated managed care procedures, and managed care restriction of provider choice may also present hurdles to seeking and following up for treatment. Since early treatment of depression and other mental health conditions and careful follow-up of at-risk children and adolescents is the best prevention, particularly stringent managed care mental health benefits for adolescents and children is problematic. Health care reform regarding children's mental health benefits continues to part of national and state debates. Significant progress can be made in reducing childhood and adolescent suicide may depend upon mental illness being treated on a par with other life-threatening medical disorders and efforts to reduce barriers to direct access to mental health care.

Preventative measures such as education of emergency room personnel, runaway shelters, pediatricians, and mental health care providers are needed. Parent should educate themselves or ask their doctors about signs and symptoms of childhood and adolescent depression and should become familiar with community resources.

Ernest J. Bordini, Ph.D. is a licensed psychologist and Executive Director of Clinical Psychology Associates of North Central Florida, P.A. and was named as a Distinguished Psychologist by the Florida Psychological Association.

CPANCF.COM (352) 336-2888