BJPsych Open (2019)
5, e39, 1–3. doi: 10.1192/bjo.2019.27

Editorial

Young migrant mental health difficulties and suicidal behaviours: an alternative perspective

Theodore A. Petti and Andrew Chen

Summary

The Saving and Empowering Young Lives in Europe (SEYLE) study brings attention to the special needs of adolescent migrants. Alternative data analyses could lead to improved service delivery and requisite education/training of health and mental health personnel. We advocate earlier identification by using SEYLE data to shape policy about youth suicidal behaviour and ideation in prevention efforts.

Declaration of interest

None.

Keywords

Self-harm; suicide; adolescents; migrants.

Theodore A. Petti (pictured) is a professor of psychiatry at Rutgers Robert Wood Johnson Medical School, USA. **Andrew Chen** was a medical student at Rutgers Robert Wood Johnson Medical School at the time of manuscript submission. He is currently a resident in psychiatry at Stony Brook University Hospital, USA.

The impact of migrants across Great Britain and Europe has generated considerable attention within the European Union but there has been little consideration about the fate of migrant youth. McMahon and associates[1] report, from the larger Saving and Empowering Young Lives in Europe (SEYLE) study, on prevalence comparisons of adolescent migrants and non-migrants on critical mental health factors, particularly suicidal ideation and attempts. They employed the psychometrically validated Strength and Difficulties Questionnaire (SDQ)[2] in a school-based survey that was completed by over 1100 European Union migrant and non-migrant adolescents from ten diverse European Union countries.

The study found 386 (3.6%) of the adolescents reported a previous suicide attempt and that first-generation migrants reported an elevated prevalence of suicide attempts and significantly higher levels of peer difficulties compared with non-migrants. The prevalence of suicide attempts in non-migrants (3.1%) and second-generation European migrant (3.1%) groups was significantly lower than for first-generation European (6.9%), first-generation non-European (9%) and second-generation non-European (7.1%) migrants. Likewise, the prevalence of serious suicidal ideation was significantly lower for non-migrants (3.2%) and second-generation European migrants (3.4%) compared with first-generation European migrants (5.7%), non-European first-generation (6.7%) and non-European second-generation migrants (9.6%). In addition, the highest levels of conduct and hyperactivity problems were found among migrants of non-European origin. Based upon their findings, school-based support and appropriate mental health services are required to meet the complex needs of migrant adolescents.

However, by limiting data analysis to the effects of migrant generation and region of origin, McMahon and associates[1] forfeit the opportunity to fully build on the wealth of collected data to better deliver effective suicide prevention for adolescent migrants. For example, identification of greater peer problems as the only difference between non-migrant and both first-generation European and non-European migrant groups on the SDQ may explain the significant disparity in suicide attempts and serious suicidal ideation between groups and serve as a high-risk factor. The SEYLE study obtained but did not examine the following factors in relation to suicide attempts and suicide ideation: depression, hyperactivity, bullying, peer relations and non-suicidal self-injury – the latter was only briefly noted in the paper but not considered. There are data to support that these factors play an important role in the outcomes under study and they may be better for helping shape efforts for prevention and future research than the more global and clearly necessary recommendations by the European Society of Child and Adolescent Psychiatry.[1,3] The SEYLE study provides sufficient data for further analyses to identify critical risk factors to inform policy development and implement preventive programmes.

The following discussion considers the rationale for the more focused use of the SEYLE data to broaden public health interventions for suicide prevention in a highly vulnerable population. Suicide and suicidal ideation are often associated with depression, hopelessness and anxiety.[4–6] Psychomotor agitation and irritability are criteria for major depression in adolescents.[7] Depression – although neither delineated in the report nor an SDQ item – is represented in the SDQ[2] emotional problems scale as 'often unhappy, downhearted', as agitation in the hyperactivity scale, and irritability as temper tantrums as possible proxy in the conduct disorder scale. Moreover, greater levels of hyperactivity strongly suggest the presence of attention-deficit hyperactivity disorder (ADHD), with its associated propensity to risk-taking behaviour that can predispose an individual to migrate to a completely different culture and increase the risk of depression.[8] ADHD is also a significant risk factor for suicidal behaviour.[9,10] The highest levels of hyperactivity and conduct problems reported for migrants of non-European origin suggests a high yield factor for future prevention screening.

More directly, the significantly higher levels of peer difficulties for all migrant adolescents should be included in any factor analysis of suicide risk factors. Although non-suicidal self-injury (NSSI) is

https://doi.org/10.1192/bjo.2019.27 Published online by Cambridge University Press

noted in the study introduction[1] to be associated with a migration history and suicide attempts, the study failed to examine this known high-risk variable for suicide.[5,11] The interpersonal–psychological theory (IPT) model[12,13] seems to fit the migrant experience and study findings. Suicide in IPT is posited to result from a combination of feeling that one does not belong or is a burden on others – common phenomena for migrant youths – when accompanied by a sense of not fearing pain or death. To complete a lethal suicidal attempt, the IPT model requires that the person overcome the fear of pain, injury and death that are associated with suicidal behaviour. NSSI can increase acquired capability for suicide by a process of desensitisation to pain and thus should be considered a priority in any screening efforts[5,14] as a significant suicide risk factor in any prevention efforts. Trauma in the migratory process itself may provide the habituation to pain and acquired suicide capacity.[12] The process of problematic acculturation in young migrants may lead to perceptions of thwarted belongingness from valued social groups such as neighbours and community, which in turn predisposes them to negative emotions towards the self and passive suicidal ideation.

Peer relations are a critical component of adolescent socialisation and development. Problems in establishing meaningful peer relations, as noted for first-generation and second-generation non-European migrant groups, are a clear risk factor for suicidal ideation, attempts and suicide. 'Rather solitary, tends to play alone' is the first item in the SDQ peer problem scale and being bullied is the fourth item. They relate to not belonging or thwarted belongingness in IPT. Bullying represents a multifaceted form of trauma that is often experienced by migrant youth as children and adolescents, especially those of different ethnicity and culture. Such trauma often begins in the country of origin.[15] Being bullied or abused can result in a sense of learned helplessness and feelings of being thwarted and not belonging. It also increases the probability of elevated anxiety, depression and numerous other psychiatric symptoms into young adulthood, predisposing migrants to suicidal ideation.[12,15–18] Thus, most adolescent migrants and their families are beset with the stress of acclimation and acculturalisation within a frequently hostile environment, while their dreams of a better life are attacked from all quarters, including from within the family.[19]

Accordingly, the SEYLE study reports the second-generation, non-European migrant group as having the highest prevalence of suicidal ideation. The colour of their skin, religion they practice and limited access to appropriate services may have served as barriers to effective integration into society,[1] but lack of appropriate education and training of vulnerable migrant adolescents and emerging adults and those of the professionals offering them care may be more critical in light of the IPT model of suicide with regard to feeling thwarted in their desires and efforts to be a part of society. These factors affect the first-generation adolescent migrants and, as the SEYLE study demonstrates, will most severely affect the second generation of non-European adolescent migrants with surges of reported discrimination and xenophobia. The possibility that migrant adolescents feel thwarted and isolated from society needs to be considered in any public health responses to a world that is witnessing high rates of displacement within many countries.

Likewise, McMahon and associates note that post-migration factors in non-European migrants may be more important than the migratory experience as mediators of suicide risk and behavioural difficulties.[1] They recommend evidence-based universal mental health promotion programmes with demonstrated effectiveness delivered in all schools and to address perceived deficits in healthcare delivery; these recommendations certainly need implementation but may not address the most vulnerable adolescent migrants at risk for suicide, i.e. those who do not have access to schools, who are not regularly attending school due to a psychiatric illness, who are dropping out to financially support the family or who fear bullying and related factors. Their recommendation does not include the need to screen for psychiatric illness. Many migrant families have struggled to accommodate to the inherent stresses of immigration. The need to systemically address the personal needs of individual first-generation adolescent migrants and second-generation non-European migrants at risk for suicidal ideation, NSSI and suicide attempts will not be easily attained,[20] but arguably should begin with screening efforts.

Early identification of those enrolled in school who are struggling, disruptive or truant and those presenting with delinquency should be given priority in screening for NSSI and suicidal risk factors, including screening for bullying. Screening tools with reasonable reliability and validity are available for such selective screening, e.g. the Columbia-Suicide Severity Rating Scale (C-SSRS)[21] or any one of several scales to screen for ADHD, anxiety or depression. A history of NSSI should be considered a high-risk factor for suicidal behaviour as especially should a prior suicide attempt[5] or both.[22] Another option is to construct a template from items in the SDQ or related scale that are highly correlated with prior suicide attempts or suicidal ideation, as would be possible from the SEYLE data-set.

Interventions in schools and training programmes for professionals to identify and treat vulnerable children should be pursued as McMahon and associates suggest. Better systematic early identification of migrant youth is paramount for those most at risk for suicidal behaviour. The SEYLE study results with additional data analysis and addition of NSSI items can serve as a useful guide for this purpose. Evidence-based treatments are becoming more readily available but beyond this editorial's scope. Further systematic research must be pursued and funded to explain the SEYLE results and, as efforts continue, to improve access to social support and healthcare for at-risk migrant youth.[23]

In conclusion, the SEYLE study delineates critical stressors and issues concerning adolescent migrants[1] and appropriately focuses upon behavioural and suicidal outcomes. This editorial perspective elaborates more directly on suicide-related factors and the need to focus more directly upon the youth at greatest risk in light of relevant theories of suicide and NSSI. The same recommendations made by Lustig and associates[24] hold today, especially in light of insights provided by SEYLE: interventions that address cultural relevancy and efficacy that impact on multiple aetiological levels. Early identification through monitoring risk factors is essential for effective suicide prevention in vulnerable migrant populations.

Theodore A. Petti, MD, MPH, Professor of Psychiatry, Rutgers Robert Wood Johnson Medical School, USA; **Andrew Chen**, MD, Resident in Psychiatry, Stony Brook University Hospital, USA

Correspondence: Theodore A. Petti, 671 Hoes Lane West, Piscataway, NJ 08854, USA. Email: pettita@rutgers.edu

First received 9 Feb 2018, final revision 18 Mar 2019, accepted 8 Apr 2019

References

1 McMahon EM, Corcoran P, Keeley H, Cannon M, Carli V, Wasserman C, et al. Mental health difficulties and suicidal behaviors among young migrants: multicenter study of European adolescents. *BJP Open* 2017; **3**: 291–9.

2 Goodman R. Psychometric properties of the strength and difficulties questionnaire. *J Am Acad Child Adolesc Psychiatry* 2001; **40**: 1337–45.

3 Anagnostopoulos DC, Heberbrand J, Eliez S, Doyle MB, Klasen H, Crommen S, et al. European Society of Child and Adolescent Psychiatry: position statement

https://doi.org/10.1192/bjo.2019.27 Published online by Cambridge University Press

on mental health of child and adolescent refugees. *Eur Child Adolesc Psychiatry* 2016; **25**: 673–6.

4 Ori M, Galera C, Turecki G, Forte A, Renaud J, Tremblay RE, et al. Association of childhood irritability and depressive/anxious mood profiles with adolescent suicidal ideation and attempts. *JAMA Psychiatry* 2018; **75**: 465–73.

5 Muehlenkamp JJ. Distinguishing between suicidal and nonsuicidal self-injury. In *The Oxford Handbook of Suicide and Self-Injury* (ed MK Nock): 23–46. Oxford University Press, 2014.

6. Joiner TE, Rudd MD. Disentangling the interrelations between hopelessness, loneliness, and suicidal ideation. *Suicide and Life-Threatening Behav* 1996; **26**: 19–26.

7 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (5th edn). American Psychiatric Publishing Inc, 2013.

8 Lehti V, Chudal R, Suominen A, Gissler M, Sourander A. Association between immigrant background and ADHD: a nationwide population-based case-control study. *J Child Psychology Psychiatry* 2016; **57**: 967–75.

9 Ljung T, Chen Q, Lichtenstein P, Larsson H. Common etiological factors of attention-deficit/hyperactivity disorder and suicidal behavior: a population-based study in Sweden. *JAMA Psychiatry* 2014; **71**: 958–64.

10 Dalsgaard S, Ostergaard SD, Leckman JF, Mortensen PB, Pedersen MG. Mortality in children, adolescents, and adults with attention deficit hyperactivity disorder: a nationwide cohort study. *Lancet* 2015; **385**: 2190–6.

11 Ribeiro JD, Franklin JC, Fox KR, Bentley KH, Kleiman EM, Chang BP, et al. Self-injurious thoughts and behaviors as risk factors for future suicide ideation, attempts, and death: a meta-analysis of longitudinal studies. *Psychol Med* 2016; **46**: 225–36.

12 Kene P, Brabeck KM, Kelly C, DiCicco B. Suicidality among immigrants: application of the interpersonal-psychological theory. *Death Studies* 2016; **40**: 373–82.

13 Joiner TE, Ribeiro JD, Silva C. Nonsuicidal self-injury, suicidal behavior, and their co-occurrence as viewed through the lens of the interpersonal theory of suicide. *Curr Dir Psychol Sci* 2012; **21**: 342–7.

14 Selby EA, Joiner Jr TE, Ribeiro JD. Comprehensive theories of suicidal behavior. In *Oxford library of psychology. The Oxford handbook of suicide and self-injury* (ed MK Nock): 286–307. Oxford University Press, 2014.

15 Srabstein JC. The global implications of bullying and other forms of maltreatment, in the context of migratory trends and psychiatric resources. *Child Adolesc Psychiatr Clin N Am* 2015; **24**: 799–810.

16 Hertz MF, Donato I, Wright J. Bullying and suicide: a public health approach. *J Adolesc Health* 2013; **53**: S1–S3.

17 Klomek AB, Kelinman M, Altschuler E, Marrocco F, Amakawa L, Gould MS. High school bullying as a risk for later depression and suicidality. *Suicide Life Threat Behav* 2011; **41**: 501–16.

18 Teicher MH. Hurtful words: association of exposure to peer verbal abuse with elevated psychiatric symptom scores and corpus callosum abnormalities. *Am J Psychiatry* 2010; **167**: 1464–71.

19 Rothe EM, Tzuang D, Pumariega AJ. Acculturation, development, and adaptation. *Child Adolesc Psychiatr Clin N Am 2010*; **19**: 681–96.

20 Giacco D, Matanov A, Priebe S. Providing mental healthcare to immigrants: current challenges and new strategies. *Curr Opin Psychiatry* 2014; **27**: 282–8.

21 Posner K, Brown GK, Stanley B, Brent DA, Yershova KV, Oquendo MA, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *Am J Psychiatry* 2011; **168**: 1266–77.

22 Brausch AM, Williams AG, Cox EM. Examining intent to die and methods for nonsuicidal self-injury and suicide attempts. *Suicide Life-Threatening Behav* 2016; **46**: 737–44.

23 Chau K, Kabuth B, Chau N. Association between suicide ideation and attempts and being an immigrant among adolescent, and the role of socioeconomic factors and school behavior, and related health difficulties. *Int J Environ Res Public Health* 2016; **13**: 1070.

24 Lustig SL, Kia-Keating M, Knight WG, Geltman P, Ellis H, Kinzie JD, et al. Review of child and adolescent refugee mental health. *J Am Acad Child Adolesc Psychiatry* 2004; **43**: 24–36.

https://doi.org/10.1192/bjo.2019.27 Published online by Cambridge University Press