

Suicide and Parasuicide in Childhood and Early Adolescence

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Suicide is intentional self-killing, and parasuicide an act of deliberate self-harm—either by injury, ingestion or inhalation—not resulting in death (Black *et al*, 1982). Both are rare under the age of 12 and the rate of suicide in those under 16 remains consistently low. Referrals to psychiatric services reported by Shaffer (1974) indicated that 7–10% were for threatened or attempted suicide, while Hawton (1982) quoted studies giving the incidence as 10–33% for children aged six to 12; in England and Wales (1962–1968), suicide accounted for 0.6% of deaths in the 10–14 age-range. McClure (1984) found that between 1975 and 1980, only ten such deaths were recorded in the 13-and-under range, and 26 deaths in the 14 year-olds, after which the number of suicides rose sharply with each successive year. That study also showed that parasuicide was most common in the 15–24 age-group, but at younger ages there was a higher proportion of undetermined deaths, as against officially recorded suicides. The social taboos associated with suicide may lead to its systematic under-reporting, but even allowing for that, the phenomenon is still a rare one under the age of 16.

In the Oxford region, 4.7% of general hospital admissions of 12–20 year-olds in 1974–1979 were due to adverse effects of medicinal agents (Hawton & Goldacre, 1982), while Skegg *et al* (1983) found that in a two-year period, 7.89% of self-poisoners were 10–14 years of age. Black *et al* (1982) state that 6–8% of parasuicides occur in the under-12 age-group, the rate of hospital admissions rising sharply from the age of 12, with peaks at 16 for females and at 18 for males.

Seventy per cent of young suicides are males (Anderson, 1981), though between 1970 and 1980, the rate in the 10–14 age-group declined for males and rose for females, while that for both sexes increased in the 15–19 years range; the male to female ratio was about 2:1 (McClure, 1984). On the other hand, 80–90% of young parasuicides are female (Anderson, 1981). Hawton (1982) found a marked female preponderance in younger patients and in those who take overdoses rather than injure themselves, which may be because girls mature earlier than boys and because self-poisoning is culturally less acceptable among males, who have

alternative outlets, such as aggressive behaviour, for expressing distress.

Classification

Schrut (1964) divided 31 children and adolescents seen at a suicide prevention centre in Los Angeles into those who were depressed and those both hyperactive and aggressive. Hawton *et al* (1982c) classified adolescent overdosers into three sub-groups, which varied in the duration of their problems and in the presence or absence of behavioural disturbances; family characteristics differentiating the groups were similar to those reported to distinguish psychiatrically disordered from normal adolescents. The groups differed markedly in their medical and psychiatric histories, in the nature of their overdoses, and in the problems they faced at the time; these same factors may also distinguish between subjects in terms of outcome, including subsequent adjustment and repeated attempt. Taylor & Stansfeld (1984) stated that it would be misleading to use the term 'overdose' as a diagnostic category, while Halasz (1984) felt it was essential to distinguish between accidental poisoning, suicidal behaviour, and a form of child abuse.

Methods used

Ninety two per cent of parasuicides are drug overdoses, but this method accounted for only 13% of young suicides (Shaffer, 1974), although there has been an increase in poisoning, particularly in female suicides amongst 10–14 year-olds in the period 1951–1980. Analgesics, antipyretics, and psychotropics account for 75% of adolescent overdoses (Hawton & Goldacre, 1982); Skegg *et al* (1983) found psychotropics to be the commonest drugs used by parasuicides aged ten and over, while Hawton (1982) reported analgesics as being the commonest. He confirmed an association between males, self-injury, and greater lethal intent which was earlier reported by Shaffer (1974).

Reasons given

Shaffer (1974) found that of those who committed suicide and left notes, 35% said they had recently been "in trouble". Parasuicide may be to get back

at others or change their behaviour, to gain relief from stress, or to show how desperate the subject felt, but is rarely to gain help (Hawton, 1982). Lumsden Walker (1980) found that a quarrel with a parent or sweetheart is a common reason and that only 8% regretted not having died by the time of interview, but that 22% were indifferent, uncertain, or unhappy about their survival. However, Hawton *et al.*, (1982a) found that one-third of adolescent parasuicide cases said they had wanted to die.

Associated factors

Abuse: Anderson (1981) implicated sexual abuse in four suicidal girls, while Green (1978) found a high incidence of self-destructive behaviour in 60 abused children, and Hawton (1982) reported a connection between physical abuse and repeating parasuicide. Twenty per cent of 50 self-poisoners reported by Taylor & Stansfeld (1984) had documented evidence of physical ill-treatment.

School: Social isolation by school absence may facilitate suicidal behaviour (Teicher & Jacobs, 1966; Hawton, 1982): poor academic progress and disturbed relationships with teachers have also been noted in the histories of parasuicide cases. Forty per cent of parasuicides had missed over two weeks' schooling in the past term (Lumsden Walker, 1980), while 57% of young male suicides were not at school the day before their death (Shaffer, 1974), and a quarter of these were chronic school refusers.

Physical health: 50% of adolescent overdosers had visited the family doctor in the previous month, and 24% in the previous week (Hawton *et al.*, 1982b). Shaffer (1974) noted that a significant number of suicides were tall, and precocious both physically and mentally.

Mental health: Psychiatric illness was found in only a minority of parasuicides by Hawton (1982), while Lumsden Walker (1980) put the figure at 20%; depression was mentioned by both, and was more likely to be found in males. Taylor & Stansfeld (1984) found that self-poisoning children showed more psychiatric symptoms than a matched control group of psychiatric referrals, that they spanned a wide range of diagnoses, and that self-injury was associated with depressive disorder in children, but that only a minority were depressed. Hawton (1982) found more evidence of disturbed behaviour in repeaters, and Shaffer (1974) that 50% of suicides had had behavioural or emotional problems.

Anti-social behaviour: Tuckman & Connon (1962) reported that one-third of adolescent parasuicides had been involved in delinquent acts, both types of behaviour being regarded as attempts to control the environment. Twenty eight per cent of parasuicides had been involved with the police (Lumsden Walker, 1980), while 56% of suicides had anti-social symptoms (Shaffer, 1974); Taylor & Stansfeld (1984) found a strong association between self-poisoning and running away from home.

Aetiology

Anderson (1981) listed hate, revenge, loneliness, isolation, shame, guilt, and loss of self-esteem as reasons for adolescent parasuicide. Kerfoot (1980) reviewed the literature and divided aetiological factors into two groups—psychodynamic and family:

Psychodynamic factors—(a) childhood parental deprivation (Koller & Castanos, 1968). (b) parent-child role reversal (Kerfoot, 1980). (c) sexual difficulties and hostility aimed at the parents (Schneer *et al.*, 1961). (d) hostility and aggression employed inwardly (Freud, 1958). (e) an identity perversely based on identifications and roles, which at critical stages of development have been presented as most undesirable or dangerous and yet as most real (Erickson, 1968).

Family factors—(a) Relationship problems: Margolin & Teicher (1968) found that the majority of mothers were immature, deprived in personality functioning, and unable to respond effectively to the children's needs, while fathers were absent or, if present, were regarded with indifference or dislike by the children. Emotionally detached parents make the children feel a burden (Schrut, 1964); lack of warmth among family relationships was a striking associate of self-injuring children and likely to be an aetiological factor (Taylor & Stansfeld, 1984). (b) Extremes of parental expectation or control (McIntyre *et al.*, 1977). (c) Psychiatric disorder in a close relative, especially parasuicide in a close relative or friend (Hawton, 1982; Lumsden Walker, 1980); (d) Alcohol abuse in a parent (Shaffer, 1974). (e) Loss by death, desertion, or separation from a significant person (Hawton, 1982; Koller & Castanos, 1968; Margolin & Teicher, 1968).

Shaffer (1974) postulated that what may determine suicide is: (a) a degree of conceptual maturity. (b) a disturbed family background. (c) a depressed mental state. (d) a precipitant, often of a humiliating kind. (e) access to the means of suicide, with opportunity to use this in isolation. (f) close

experience of suicidal behaviour in the family, in the peer group, or at a fantasy level.

Management

Black *et al.* (1982) recommended short-term hospital admission for most cases of parasuicide, with children under 12 going into a paediatric ward, young adolescents to a paediatric or adolescent ward, and older adolescents to an adolescent or adult ward. If admissions are restricted to one or two wards, the psychiatric team can offer regular consultations to the staff.

Management of the physical state takes priority, but even if this in itself does not require admission, a short stay in hospital is desirable to allow for psychiatric and social evaluation, while providing a respite from a possibly stressful situation; the size of an overdose is not a good indicator of the degree of psychopathology. An assessment of the patient and family should occur within 48 hours and the psychiatric team should be directly involved, but should this not be possible, a non-psychiatrically trained person may make the assessment if consultation with the team is easily available. Taylor & Stansfeld (1984) recommended admission for urgent in-patient assessment by members of a child psychiatric team.

Although one-third of the parasuicides studied by Hawton *et al.* (1982a) said they had wanted to die, lethal intent was only perceived by the clinical assessors in seven cases, the rest being attributed to punitive or manipulative reasons. There is thus a dilemma between the patient's feelings and attitudes and the assessor's theoretical assumptions. In assessing suicidal risk in a parasuicide, Stengel (1963) suggested asking what change has the parasuicide brought about in causative factors, as well as ascertaining the reactions of the human environment to the parasuicide.

Only a few parasuicides are likely to need transfer to residential care, either a psychiatric in-patient unit or a children's home. The family doctor should be notified, and Hawton (1982) felt that one-third could be referred back to the GP's care. Although Black *et al.* (1982) stated that follow-up should always be offered, which may be with another agency if one is already involved, Hawton *et al.* (1982a) found that only 8% had wanted help. This may account for the poor attendance at psychiatric follow-up, particularly by those with chronic behaviour problems (Lumsden Walker, 1980). However, Taylor & Stansfeld (1984) reported that 28 of the 50 child self-poisoners whom they had studied kept a psychiatric out-patient appointment, and that parental attitudes and

background as well as the child's mental state affected the likelihood of returning for treatment. Their main prediction for further attendance was based upon the presence of affective symptoms in the child.

Hawton *et al.* (1982a) suggested that psychiatric treatment should primarily focus on the patient's feelings of anger and rejection. Black *et al.* (1982) point out that in the younger child, family disturbance may be more serious, and that the child may have unrealistic or inconsistent notions of death and of the harmful physical effects from parasuicide.

Prognosis

Short-term prognosis for most parasuicides is relatively good, but 10–14% make a further attempt within a year (Hawton, 1982). Factors associated with repeated parasuicide have been discussed by the same author, while Stengel (1963) related the danger of an early repetition to the appeal effect on the human environment.

The long-term follow-up of a controlled group of Swedish adolescent parasuicides by Otto (1972) showed a higher death rate (principally from suicide), a greater crime rate, more physical illness, lower marriage rates, higher divorce rates, and a higher rate of emigration; 4.3% had committed suicide, the risk being highest in the first two years. Females most likely to die were those who were young when they first tried and those using violent means. Nardini-Maillard & Ladame (1980) interviewed 13 adults who had been adolescent parasuicides, and found a variety of later disturbances.

Prevention

The impulsivity and lack of motivation for help in parasuicides makes prevention difficult (Hawton *et al.*, 1982a). As drug overdose is the commonest method used, the question of changing prescribing habits has been raised, but analgesics can be bought without prescription. Several authors suggest that more care should be taken in the use of psychotropics with young people.

Hawton (1982) felt that educational measures aimed at modifying attitudes to self-poisoning, possibly using the mass media, may be useful in schools, while recommending a closer collaboration between child and general psychiatrists to improve the identification and treatment of young people at risk and of their parents. Ladame & Jeanneret (1982) drew attention to the relatively weak predictive power of each identified risk factor and to the large investment of energy, professional skills, time, and money inherent in any preventive

programme. They state that primary prevention should centre on detecting depressive illness, signs of alienation, and mounting anxiety; it would consist of a set of non-specific measures dealing with the educational, psychological, and societal conditions which influence the maturational processes from childhood to adolescence. Secondary prevention, on the other hand, must consider the future of the young parasuicide; improving his long-term prognosis requires changes in the individual mind and life style, and in the familial and social environment. As well as aiming to prevent further suicides, it should focus on the risk for adolescent parasuicides of becoming adults exposed to increased mortality, morbidity, and psychosocially handicapping conditions.

It is unlikely that any single such programme will suit all children, but the prevention of suicide and overdose is not the only goal of intervention, or effective out-patient psychiatric treatment could make a useful contribution to the secondary prevention of further overdoses (Taylor & Stansfeld, 1984). It is likely that prevention for those self-poisoning children who do not show a significant degree of distress will need to be based upon kinds of intervention different from out-patient psychiatric treatment.

Discussion

In recent years, a growing awareness and concern

about both parasuicide and suicide in children and young adolescents has been reflected in the literature, with the emergence of clearer guidelines on the need for assessment, appropriate management, and possible modes of prevention. However, Hawton (1982) drew attention to some of the unanswered questions. Why do more girls than boys take overdoses? What are the responses of significant persons, especially parents, to the parasuicide? What are the attitudes to self-poisoning among teenagers in general, especially those at risk, and how might these be influenced in a preventive fashion? The value of different kinds of help now needs to be more formally assessed.

Though attention has also been drawn to the possibility of the under-reporting of death by suicide in this age-group, how may this possibility be further explored? Kerfoot (1980) emphasised psychodynamic and family factors in the aetiology of parasuicide and suicide, but what, if any, socio-cultural factors may play a part in regard to these children and young adolescents? Does the availability of drugs to young people need control? Why do more males than females commit suicide at this period of life? There are clearly many areas for future research.

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