GENERAL PAPERS

PARTICULARITIES OF SUICIDAL BEHAVIOR IN CHILDREN AND ADOLESCENTS

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ABSTRACT

The frequency of suicidal behavior in children and adolescents has increased significantly in recent years, representing a plurifactorial phenomenon, with determining factors in both psychiatric disorders, especially depression and conduct disorders, and also environmental factors including dysfunctional families, academic failure, faulty relationships, including an issue of increasing interest which lies on the border between illness and social factor, represented by the abuse of psychoactive substances. Approaches remain unorganized and inadequate, thus maintaining a real interest in the folowing subject, child and adolescent suicide, and furthermore raising the issue of improving the means of effective intervention for this situation of global importance.

Keywords: suicidal behavior, children and adolescents, depression in children, dysfunctional families, substance abuse

INTRODUCTION

Suicide is certainly the third cause of death in the world for the population aged between 15 to 24 years and the fourth leading cause of death among children 10 to 14. Frequency of suicide in adolescents has quadrupled in the last decades. For instance, in 2002, there were 877,000 successful suicide attempts in the world, of which about 200,000 were under the age of 18. For exemple, of 4 million autolytic attempts occurring annually, about 90,000 occur in people aged 10 to 19 years. Moreover, between 12-25% of children and adolescents have suicidal thoughts at some point. Every suicide in children/adolescents is associated with around 100 autolytic attempts. While girls are more exposed to suicidal behavior without fatal suicide attempts, boys have a higher rate of successful attempts (10, 12).

Suicidal behavior may be due to a genuine desire to die but can also be a desperate cry for help for a child/adolescent who feels overwhelmed by certain life situations, unable to foresee a favorable outcome (10).

Normally in this stage of life young people tend to associate it with vitality, carefree and looking boldly ahead, trying to realize their hopes and dreams, so it is very difficult to accept and understand the suicide phenomenon in children and adolescents (10).

Decisive factors of suicidal behavior in children and adolescents

The main risk factors for suicidal behavior in this population are depression, conduct disorders, dysfunctional families, substance abuse, school failure or physical and emotional abuse (2,3,4,10, 11).

Some authors state that hopelessness is a more accurate predictor, so suicidal ideation may be assimilated as the ultimate desire to escape from what

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seems unsolvable or intolerable. Adolescence is a critical period with numerous changes that require a certain level of adaptability which results in playing a definitive role in life.

Frequency of depression in children has increased dramatically in recent years, from 7 to 14% of them going through a major depressive episode by age 15. Before puberty the risk for developing depression is equal in both sexes. By age 15, girls are twice as exposed to major depressive episodes. Children with depression typically show a constant feeling of discouragement, a marked decrease in self-esteem, loss of interest in pleasurable things, signs that only tend to continue over time. Depression in children requires specific treatment like psychotherapy or medication, otherwise the symptoms can persist for months and even years, involving major risks, leading to suicidal behavior, which is mainly caused by low levels of serotonin (12). On the other hand, recent data indicates a potential increase in the risk of suicide in children/adolescents treated with selective serotonin reuptake inhibitors (most commonly prescribed to treat depression), the initiation of this therapy requiring careful monitoring (3,11).

Also, conduct disorders maintain uncontrollable rage, inobedience and conflicting attitude, usually directed towards figures representing authority but sometimes can turn to himself, taking the form of suicidal behavior (1.10).

Dysfunctional families can lead the child or adolescent to assume an autolytic behavior, playing a key role in emotional stability of its members and having the greatest impact on children and adolescents who require a stronger emotional support. Poor communication within the familly, quarrels, lack of affection and cohesion among members are the main factors contributing to the emergence of suicidal behavior among children and adolescents. In addition, numerous studies have shown that a family history of suicide/suicide attempt constitutes an increased risk for autolytic behavior (genetic transmission, or inherited psychiatric disorders or the presence/persistence same harmful environmental factors) (4,10).

The use of toxic substances is a common element in those with potentially suicidal behavior and arises from ineffective coping mechanisms, forming a bridge between depression and autolytic conduct, generating feelings of emptiness, worthlessness. Substance abuse among children and adolescents is an increasingly pressing contemporary issue, which on the one hand causes psychiatric disorders in addition to the somatic impact, on the other hand is part of society because for acceptance in certain groups children and adolescents have to consume certain substances (10,12).

Emotional and physical abuse is another fundamental aspect of suicidal behavior in children and adolescents. A frequent form is bulling, that represents the pressure put at school by children/adolescents stronger (physically or in the popularity.) on weaker ones, causing them low self esteem, tendency to isolate and feeling of captivity in an otherwise hopeless situation. Also potential sexual or emotional abuse from adults at school or even in the family and other forms of physical abuse that have strong emotional impact on the child/adolescent can result in oneself beeing overwhelmed, thus wanting to end his life. (2,10,12)

Academic failure itself is not a trigger, but when associated with pressure from school, personal discontent due to poor academic results or lack of affection from social media/family, all of those can lead to suicidal behavior (8,10,12).

Other risk factors commonly involved in the occurrence of an autolytic behavior in children and adolescents are discontent over their own image (far more commonthese days due to the change of the ideal beauty and increased eating disorders in children/adolescents, especially in females), frequent changes of residence, emotional instability, impulsivity, ADHD, financial difficulties, chronic disease, traumatic experiences and sexual identity conflicts (still seen in the form of social taboos and thus the of non-acceptance) (1,7,10,12).

The concept of death to child/adolescent

It is widely accepted that to understand the concept of death is required a certain level of cognitive maturity, thus being able to establish an autolytic purpose.

There was proposed three stages of the acceptance of death during childhood (9). Children under 5 are not able to distinguish between life and death, thus rejecting the irreversibility of death and comparing it with a trip or a dream. Children between 5 and 9 years realize death but personify it, considering it as an avoidable phenomenon. Children over 9 years understand that death is an inevitable and irreversible process leading to the extinction of the person.

The spectrum of suicidal behavior in children/adolescents

Since 1994, Mardomingo, suggested that the spectrum of suicidal behavior in children/adoles-

cent includes successful attempts of suicide, suicide attempts and suicidal ideation (6). Successful suicide attempts are represented by autolytic voluntary acts that result in death of the minor. Suicide attempts are represented by the desire to harm himself, accompanied by autolytic acts which don`t result in death. This definition does not include attempts to manipulate the entourage. Suicidal ideation can range from ideas about the futility of life to actually plotting the act of suicide itself.

There are two hypothesis, one based on the progress from suicidal ideation to suicidal attempts and finally to self induced death and the other one that states that people with suicidal behavior have specific characteristics that differentiate children and adolescents who commit suicide compared to the general population. On the basis of the second theory there are two subgroups of children and adolescents with suicidal behavior.The first group has a poor prognosis (as autolytic lethal methods are used and pacients are more prone to have a successful suicide attempt), is characterized by the presence of psychiatric or environmental factors, child /adolescent not reacting to a clear trigger, but against a situation perceived as not favourable overall. The second group is represented by children/adolescents who don`t have a psychiatric history or family difficulties, but who act impulsively in a stressful environment in order to change the situation, that is being regarded as hostile (10,12).

In any event, any suicidal act, be it ordinary or not should be approached as a medical emergency. The fact that a child/teenager resorts to self-harm in order to end an unbearable situation or attracting alarm over it, indicates a high vulnerability and requires providing appropriate and specialized treatment (5,8,10,12).

The increase in recent years in the number of children and adolescents exhibiting suicidal behavior is alarming. It must be emphasized that children and teenagers today have a different way of living to those a few decades ago. Suicide is more and more common at younger ages.

Research on suicidal behavior, particularly in children, is altered by a number of methodological factors. First, most of the times, the real reason for suicide can not be established because the victim's entourage try to disguise it, given the potential social stigma which exhibit this type of behavior. Moreover, in the case of children and adolescents, parents fear that they could be held responsible for the actions of the victim.

Another difficulty in gathering information is related to the fact that the affected population can not be studied directly and thus, in some cases, can not accurately determine if it was suicide, accident or impulsive action, unpremeditated (5,10).

CONCLUSION

In conclusion it is necessary a deeper study of the problem, given the dramatic increase in the frequency of suicide in children and adolescents. Thus, it is necessary to differentiate between suicide related to a neurobiological morbid process to suicide related to a profound desire to die from the child/adolescent. Also, it is necessary a better understanding and assessment of risk factors that can lead to suicide. On the other hand, the vicious circle of depression – selective serotonin reuptake inhibitor class – suicide remains an open debate as to optimize treatment protocols in children and adolescents with depression and therefore at risk of suicide.

The social and especially family intervention to limit the access of children/adolescents to psychoactive substances, fireguns, etc. may decrease the number of suicide attempts. The main objective in this area should be to establish protocols for diagnosis/early detection of risk factors, which could then lead to the development of effective methods for the prevention of suicidal behavior in general and suicide in particular. Children who show autolytic behavior should not be underestimated, despite the fact that they can use it in a manipulative way, because they are highly exposed to commit suicide in the future.

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