

Adolescent suicide

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Suicide is relatively uncommon in Australia (1.7% of all deaths in 2003) but the human and economic costs are substantial. National concern during the 1990s focused on youth suicide, prompted by the observation that suicide rates for young males aged 15-24 had roughly tripled during the 30 years to 1990 (while rates at older ages had tended to decline). In 2003, suicide accounted for 19.9% of total male deaths and 13.1% of total female registered deaths in this age group.

Tackling the problem

Failure to detect suicide risk might be explained by the belief that asking about suicidal thoughts increases the risk that people will act on the same. This is not the case. Detailed checklists and teaching practices have been developed and can be used for assessing a patient's level of suicide risk.

The ability of practitioners to take appropriate action is made difficult because no single intervention has been shown to reduce suicide. There is insufficient evidence on which to make firm recommendations about the most effective forms of treatment for patients following a suicide attempt.

This then requires the practitioner to thoroughly assess the suicidal individual in terms of the predisposing, precipitating, perpetuating and protective factors in relation to their suicidal behaviour. This should be used to produce an individualised treatment strategy.

Research findings

Research by the Kids Help Line based on 1,800 calls from young people found that young people who expressed suicidal thoughts, intentions or behaviours, most commonly phoned about:

- ◆ Mental health problems (18% disclose suicidal thoughts or behaviours)
- ◆ Sexual abuse (9%)
- ◆ Emotional abuse (8%)
- ◆ Self image (7%)
- ◆ Sexual assault (6%)
- ◆ Grief and loss (5%)
- ◆ Cult or gangs (4%)
- ◆ Eating behaviours (4%)
- ◆ Physical abuse (4%)
- ◆ Loneliness (3%)

Callers are at highest risk of suicide when experiencing:

- ◆ A clinically diagnosed mental health disorder (22%)

- ◆ Loneliness resulting in long-term social dislocation (18%)
- ◆ Regular sexual abuse (14%)
- ◆ Unresolved issues related to past sexual abuse (13%)
- ◆ Persistent low self-value or severe feelings of worthlessness (13%)
- ◆ Severe health problems from continued disordered eating behaviours (12%)
- ◆ Regular and/or severe emotional abuse (11%)
- ◆ Current risk of injury from physical abuse (10%)
- ◆ Social isolation (6%)

Recommended approach

Guidelines formulated by the Australian Psychological Society recommend that practitioners be guided by specific principles – patient safety, safety of others, and the impact on others of suicidal behaviour.

Assessment should be comprehensive, addressing suicidal thoughts and behaviours directly in ways that attend to the pain, understand the potential for despair behind it, and provide foundations for immediate safety and ongoing help. The relative risk for suicide after attempted suicide is about 40 times higher than in the general population.

Practitioner's should explore the client's resilience and the existence of any protective factors, and build on those strengths. Some considerations are contextual and/or cultural. For example, it is pertinent to identify how a factor in the person's past, present, or imagined future may be contributing to suicidal thoughts or acts.

This has particular relevance for adolescents as their self-understanding changes over time. Adolescents view themselves in terms of "interpersonal implications" for which the organising theme is the importance of

particular features of self when interacting with others. The continuity of self depends on a stable social network. A protective conclusion might be, "No matter how much I change, my friends and family always know me".

Conversely an unhelpful conclusion that would exacerbate distress would be, "People think I am a freak, and they will always see me that way".

Dysfunctional families

The suicidal adolescent's perceptions of family dysfunction may be an independent predictor of suicidal ideation or behaviour. The following perceptions have been found to increase suicidal ideation or behaviour and depression:

- ◆ The perception of parents as uncaring or overprotective
- ◆ Difficulty with problem solving
- ◆ Affective responsiveness, that is, the person's emotions are easily triggered and tend to be strong
- ◆ Perceived poor family functioning
- ◆ Adolescent's dissatisfaction with family cohesion and adaptability
- ◆ And communication style

Risk factors

Psychiatric diagnosis was found to be the strongest risk factor for adolescent suicide. The presence or absence of various diagnostic symptoms is also relevant, whereby depressed suicide attempters were found to exhibit comparably severe mood and neuro-vegetative symptoms, than non-attempters.

Assessment should also address factors specific to the presence, immediacy and level of risk, such as:

- ◆ prior suicidal behaviour,
- ◆ suicide plans,
- ◆ access to means,
- ◆ evidence of impulsive behaviour
- ◆ use of alcohol or drugs.

Internal and external factors in the person's life and that person's unique way of responding to them will provide vital clues to an assessment that provides safe and helpful outcomes.

Treatment of suicidal ideation and behaviour in both adult and adolescent populations requires idiosyncratic case formulations in which

predisposing, precipitating, perpetuating and protective factors are identified.

Awareness of research that identifies factors that increase risk or conversely protects patients is helpful to both plan treatment and to educate the patient in terms of understanding their current state, and its impact on their ability to make valid decisions.