**ESSENTIALS OF TEENAGE SUICIDE**

**Prevention in primary care**

**KEY MESSAGES**

- Seventy percent of those who attempt suicide have a history of prior mental disorder.
- The presence of parental psychopathology significantly increases the risk of suicidal behaviour in teenagers and young adults.
- One in four South African university students was shown in a recent study to have some form of suicidal ideation.
- Impulsive suicide in childhood is associated with ADHD, conduct disorder or operational defiant disorder.
- Depression in a child or teenager presents differently from depression in adults. Depressed children/teenagers are at higher risk of committing suicide.
- SAFE-T is a useful suicide risk assessment tool.
- Education programmes in South African schools, such as 'The Teen Suicide Prevention Programme', are protective.
- Sensationalisation of a suicide at school/community/university should be avoided and professional support should be obtained to reduce rumour and contagion.

**Suicide in youth**

Suicide is the leading cause of death in adolescents and young adults and this trend appears to be increasing, according to many sources. For example, in 2004 suicide was the third leading cause of death among youths and young adults aged 10-24 years in the USA, accounting for 4599 deaths.\(^1\) The South African Stress and Health Study (SASH), conducted between January 2002 and June 2004, included 4185 South African adults and indicated the lifetime prevalence rates of suicidal ideation, suicide plans and suicide attempts to be 9.1%, 3.8% and 2.9%, respectively.\(^2\)

Relatively little is known about the aetiology and predictors of suicidal ideation and attempts in the South African setting. In all age groups mental disorders are strong predictors of suicidal behaviour, including suicidal ideation and suicide attempts. SASH utilised the World Health Organization Composite International Diagnostic Interview (CIDI) to, among others, generate psychiatric diagnoses and assess suicidal behaviour. Sixty-one percent of the total sample that reported suicidal ideation also reported having a prior lifetime DSM-IV disorder. History of any mental disorder was even higher among respondents who went on to make a suicide plan (64.0%) and a suicide attempt (70.3%).\(^3\)\(^-\)\(^5\) Further research found that the presence of parental psychopathology significantly increased the odds of suicidal behaviour among their adult offspring.\(^4\)\(^-\)\(^6\) The cumulative exposure to adverse childhood experiences also predicts later suicidality.\(^7\)

A study conducted among 1337 South African university students and published in 2016 indicated that 327 (24.46%) of the sample reported some form of suicidal ideation in the two weeks preceding data...
collection. Identifying suicidal ideation is essential in the management of suicidal behaviour. It is known that suicidal ideation is associated with increased risk of fatal and non-fatal suicidal behaviour. Furthermore, suicidal ideation has also been shown to predict impaired psychosocial functioning (e.g. dropping out), poor future psychological health (e.g. depression) and other forms of injury/risk behaviours (e.g. physical fights, sexual behaviour, substance and alcohol abuse) among university students.8,9

Two types of youth suicide

Suicide attempts in youth may be viewed in two ways, i.e. as impulsive suicide or planned suicide.

Impulsive suicide usually occurs in those children and adolescents who may have been diagnosed with ADHD, a conduct disorder or oppositional defiant disorder. Substance use disorder often plays a role, as does a history of impulsive aggression towards others. These children may or may not be depressed.

Planned suicide often occurs in the presence of a co-morbid psychiatric disorder like depression or anorexia nervosa. In these cases, the suicidal behaviour is usually carefully planned and thought out.

Attempts and completion

It has generally been shown that although girls make more attempts at suicide, boys use more lethal methods and have more completed suicides. There are about 23 suicide attempts for every completed suicide and one in 10 attempters goes on to a completed suicide later.10

Risk factors for suicide (Table 1)

<table>
<thead>
<tr>
<th>TABLE 1. Risk factors for suicide following deliberate self-harm11</th>
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<tbody>
<tr>
<td><strong>SO CIODEMOGRAPHIC</strong></td>
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<tr>
<td>• Older age</td>
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<tr>
<td>• Male sex</td>
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<tr>
<td><strong>SOCIAL AND FAMILY CONTEXT</strong></td>
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<td>• Easy access to a dangerous method, e.g. handguns in the home, especially if loaded</td>
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<td>• Continuing stressors, e.g. bullying, abuse</td>
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<td>• Close family member who has committed suicide</td>
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<td>• Exposure to violence in the home or the social environment where the individual sees violent behaviour as a viable solution to life problems</td>
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<td>• Recent losses, e.g. death of a relative, a family divorce, or a breakup with a girlfriend</td>
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<td>• Poor peer or family relationships, e.g. parental divorce and consequently less family stability</td>
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<td>• Social isolation, where the individual does not have social alternatives or the skills to find alternatives to suicide</td>
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<td><strong>CHARACTERISTICS OF THE ATTEMPT</strong></td>
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<td>• High suicidal intent</td>
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<td>• Previous suicide attempts</td>
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<td>• Dangerous method</td>
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<td><strong>CLINICAL</strong></td>
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<td>• Severe psychiatric illness (depression, psychosis)</td>
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<td>• Past psychiatric hospitalisation</td>
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<td>• Behavioural problems</td>
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<td>• Hopelessness</td>
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<td>• Substance abuse: Drugs decrease impulse control. Some attempt to self-medicate their depression with drugs or alcohol</td>
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<td>• The patient still intends to die</td>
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Warning signs

The Youth Suicide Prevention Programme (http://www.yspp.org) provides a list of warning signs for possible teenage suicide. These include:

- Suicidal talk and a previous suicide attempt
- Current talk of suicide or making a plan
- Strong wish to die or a preoccupation with death and dying
- Giving away prized possessions
- Signs of depression, such as moodiness, hopelessness, withdrawal, difficulty with appetite and sleep, and loss of interest in usual activities
- Increased alcohol and/or other drug use
- Hinting at not being around in the future or saying goodbye
- Behavioural changes and taking excessive risks
- Making arrangements to take care of unfinished business

Depression and suicide

According to the American Academy of Child and Adolescent Psychiatry (Fact Sheet No 4, July 2013: The Depressed Child), clinical research is clear that not only adults become depressed, but so do children and teenagers. In modern day medicine, depression is a treatable illness in both children and adults. It is estimated that about 5% of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression is also genetic and tends to run in families.

The symptoms of a depressed child or teenager may differ from those of depressed adults. The signs and symptoms of depression in youth may include:

- Frequent sadness, tearfulness/crying
- Decreased interest in activities or inability to enjoy what were previously favourite activities
- Hopelessness
- Persistent boredom, low energy
- Social isolation, poor communication
- Low self-esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses, such as headaches and stomach aches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self-destructive behaviour

Depressed children and adolescents are at increased risk of committing suicide.

Assessment and intervention

Several teen suicide scales exist, e.g. the Columbia-Suicide Severity Rating Scale and the Tool for Assessment of Suicide Risk: Adolescent Version Modified (TASR-Am). These are useful tools but can also be cumbersome to use at times. The National Suicide Prevention Lifeline USA (www.sprc.org) devised an easy to use guideline it terms Suicide Assessment Five-step Evaluation and Triage (SAFE-T) for mental health professionals and general practitioners (Table 2).

TABLE 2. SAFE-T: Suicide Assessment Five-step Evaluation and Triage for mental health professionals and general practitioners

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>IDENTIFY RISK FACTORS</td>
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<td>2.</td>
<td>IDENTIFY PROTECTIVE FACTORS</td>
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<td>3.</td>
<td>CONDUCT SUICIDE INQUIRY</td>
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<td>4.</td>
<td>DETERMINE RISK LEVEL/INTERVENTION</td>
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<td>5.</td>
<td>DOCUMENT</td>
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</table>

- Note those that can be modified to reduce risk
- Note those that can be enhanced
- Suicidal thoughts, plans, behaviour and intent
- Determine risk. Choose appropriate intervention to address and reduce risk
- Assessment of risk, rationale, intervention and follow-up
Prevention and education

Education and prevention remain the key to the management of teen suicide. Vulnerable teenagers should be identified early and social factors associated with suicide managed. The role of peers and schools is also important. Teens need to be aware of the warning signs of depression and suicidal thoughts. To this effect running teen suicide prevention programmes in schools (refer to the South African Depression and Anxiety Group (SADAG)) is highly effective. Worst of all is that adolescents may try to deal with suicidal friends by themselves; if there is a suicide, they are left with overwhelming guilt. Not knowing what to do may also delay effective treatment.

All schools need to have some protocol in place on how to deal with the suicidal learner or student. After a suicide, a professional crisis team should be called to the school and, above all, sensationalisation should be controlled to reduce the chance of rumour and contagion. Staff and teachers should also have adequate knowledge to identify vulnerable students.

References