Understanding suicide, suicide attempts and self-harm in primary school aged children

Evidence Summary

The thought of a child dying by suicide is confronting. It challenges ideals we hold about how children grow and develop. It raises questions about children's understandings of death and their capacity to have the intent to suicide. However, there are writings as early as 1904 suggesting that children had died by suicide (Martinez, 2013).

Defining suicide or intentional self-harm in children can be fraught as there is debate around children's understandings of death. A useful definition of suicidal behaviour in children developed by Pfeffer is "any self-destructive behaviour that has an intent to seriously damage oneself or cause death (1986, p. 14)".

Despite reports of deaths and increasing awareness of the risk in recent times, death by suicide in children is a relatively rare event. Like deaths by suicide in adolescents and adults, it is complex and multifactorial, with no one factor able to account entirely for the death. As the numbers of deaths are low, research is scant and with small numbers of case studies to drawn upon, evidence is not solid. Efforts to extrapolate from what is known about adolescent suicide is not accurate or helpful as children and adolescents differ in relation to physical, sexual, cognitive and social development.

Suicide by children is likely to be underestimated. This can be due to social stigma, shame, reluctance by officials to determine a verdict of suicide, and a misconception that children are precluded from engaging in suicidal acts due to cognitive immaturity (Kolves, 2010). However, research has indicated that, from the age of 8 years on, children understand the concept of suicide and are capable of carrying it out (Kolves, 2010, citing Mishara, 1998; Fortune & Hawton, 2007).

Given the possibility of suicide in children, families, primary school staff, health and community professionals will be keen to look for ways to prevent suicide by children in their communities. It is possible that suicidal and self-harming behaviour may be missed in primary school aged children if adults are not aware that children may be at risk of self-harming or suicide.

If a suicide attempt, self-harm or death by suicide has occurred, the family and community will need information to try to make sense of it and reduce further impacts.

This brief evidence summary is based on a systematic literature review to identify factors that might be specific to suicide risk in childhood, and thus to assist primary schools with interventions to prevent suicide.

Data

The Australian Bureau of Statistics (ABS) (2016) reported:

– Not being aware of any recorded suicide deaths of children under the age of five years.

– In 2016 suicide was the leading cause of death of children between 5 and 17 years of age.

In the period 2010 – 2014, the ABS reported:

– 88 deaths (43 males, 45 females) by suicide of children aged 5 – 14 years old.

– 305 suicides of children aged 5 – 17 years. Aboriginal and Torres Strait Islander children were over-represented (84 of the deaths) compared to non-Indigenous children in this group.

Data is available from Kids Helpline in relation to contacts by children aged 5 – 14 years for the period 2012 – 2016. This provides significant evidence in relation to their suicidal thoughts, intent and attempts. During this period, a total of 59,053 counselling contacts related to suicide were made, from 12,493 children. Of those contacts:

– 12.4% were concerned for another person;

– 82.9% reported suicidal thoughts and fears;

– 3.2% expressed an immediate intent; and

– 1.5% reported a current attempt at the time of making contact.

– 85% of these contacts were females.

Kids Helpline report that although suicidality amongst children younger than 14 years is not a new issue, having responded to it for more than 15 years, there is a clear trend of increasing contacts related to suicide with 16.9% of all counselling contacts in 2016 related to suicide, 27.6% of which were with children aged 14 years or younger.

Records of help-seeking to Kids Helpline show that children start making contact very young (from the age of 7 years), with numbers rapidly increasing between the ages of 11 and 14 years. Further, in a consultation undertaken by Kids Helpline, children aged 14 years and under were found to be just as likely to have made a suicide plan or attempted suicide as those in the older group (82% of the 136 participants aged 14 years and younger reported having made a suicide plan and 54% reported attempting suicide). This is supported by 2016 Kids Helpline data of duty of care interventions in relation to suicidality with 57 individuals aged 14 or younger receiving this intervention. Counsellors responded to an average of 2.3 contacts per week from a child 14 years or younger expressing an immediate intent to suicide or engaged in an attempt at the time of contact (Batchelor, 2017).

Although self-harming behaviours are not necessarily always related to an intention to die, links have been established between suicide and self-harm. In relation to self-harming behaviours, a large Australian study (Swannell & Martin, 2014) showed that approximately 7.6 per cent of 10 to 12-year olds reported self-harm. Anecdotally, self-harming behaviours have been witnessed in primary school aged children as young as six years.
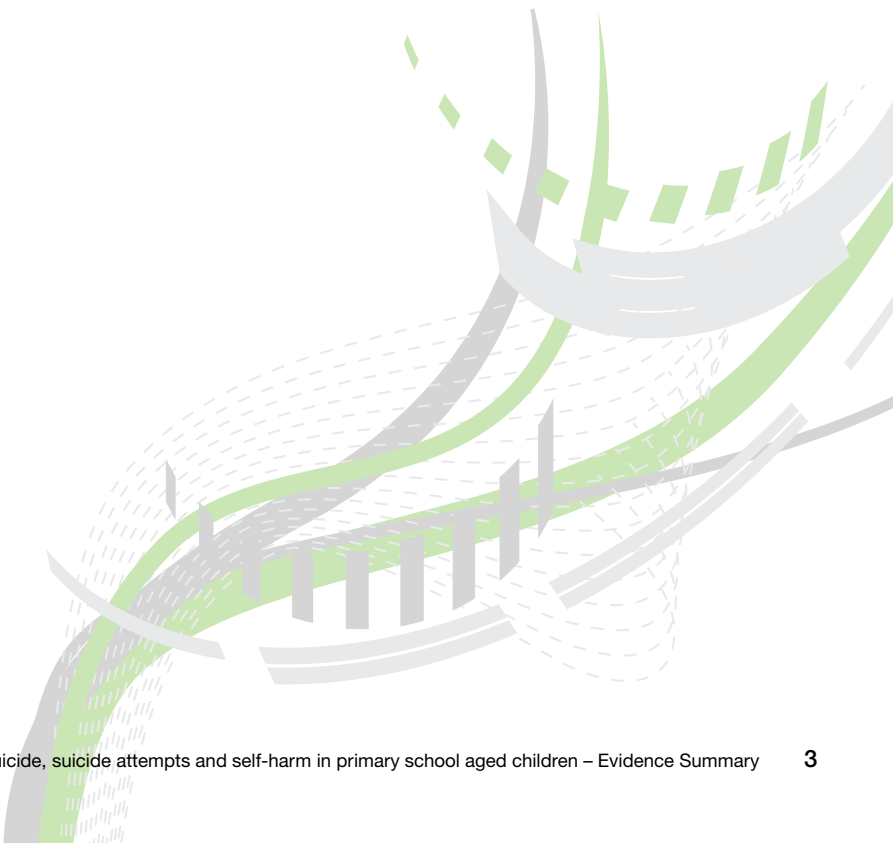
Understanding suicidality

There are few models developed for understanding suicidality in children, however, the stress-vulnerability model could be applicable to children. This model recognises the complexity of suicidality, including genetic make-up as well as acquired susceptibility which contributes to a person's predisposition or vulnerability. Early traumatic life experiences, chronic illness, chronic alcohol and substance abuse and environmental factors such as social position, culture, diet etc. all play a part in the development of vulnerability (Wasserman, 2012).
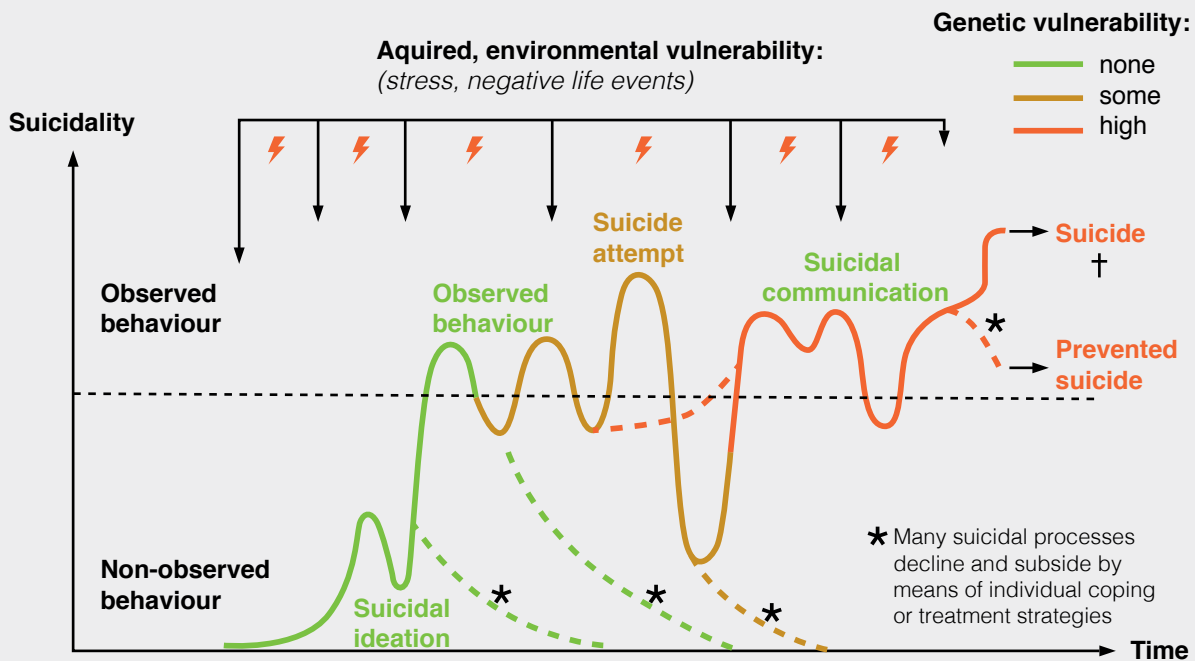
The suicidal process and its evolution on the basis of the individual vulnerability.

From D. Wasserman, C. Wasserman. Oxford Textbook of Suicidology and Suicide Prevention: A Global Perspective [155] .cited by Wasserman, et al. (2012).

Children's understanding of death

Mishara (2003) argues that for children to understand suicide they must first understand death. He suggests that preschool children first conceive of death as reversible, as not universal or inevitable. This may be based upon portrayals of death in fairy tales, where characters can be reawakened or brought back to life with magic powers, for example. Children do not retain this immature understanding of death for long and by the age of 6 – 7 years, two thirds of children understand that everyone dies and most know that we must all die one day.

Children are also exposed to death by suicide. Research from Quebec in 1999 found that half of the children aged 5 – 7 years reported seeing at least one suicide on television and older children could report on at least one such incident and usually several deaths by suicide in television programs. This was considered at that time to be the primary source of information on suicide for children of all ages, although there would be a small number of children who had experienced a death by suicide in their own family (Mishara, 2003). With increased use of internet and access to a range of media now, it is likely that children will be increasingly exposed to suicide, although there is no current research exploring this specifically.

It is becoming increasingly accepted by child development specialists that the intent to cause self-harm or death is most important, regardless of the child's cognitive understanding of the lethality, finality or outcome of their actions (Martinez, 2013).

The risk and protective factors framework as a theoretical model to help understand suicide risk in children

The risk and protective factors framework can provide a useful approach to understanding the factors which may play a role in suicide. Risk factors are characteristics or conditions that tend to increase the likelihood of suicide, while protective factors may mediate or reduce the impact of those risk factors. While this framework may be useful in understanding the types of factors which may impact, it is important to recognize that it is a model developed for population level understandings rather than understanding the specific circumstances related to an individual child (Commonwealth Department of Health and Aged Care, 2000).

It is clear from the framework, however, that suicidal behaviours occur within a complex web of factors which come together to increase the likelihood of risk of harm. It helps us to understand that no one factor on its own leads to suicide, but rather a combination of factors. Protective factors may or may not be sufficient to mediate or reduce the risk, although of course efforts to reduce risks and build protective factors are useful ways to work towards suicide prevention. Suicidal behaviour has been considered to be a developmental process that begins at an earlier phase of the life cycle than when this behaviour becomes most obvious, so a focus on understanding risks and opportunities for prevention of those risks has been recognized (McClanahan & Omar, 2012; Wasserman, et al., 2012).

It is important to note that risk factors relating to suicide are largely unstudied in prepubertal children and have usually been inferred from adolescent studies. However, inferences should only be made with considerable caution (Gvion & Apter, 2016). For this reason, the following list of potential risk factors only outlines research findings in relation to factors which are considered to have played a role in children's death by suicide. In some cases, the research has considered both children and adolescents and where it appears relevant, it has been included. It is particularly important to note that suicides in children may follow only a brief period of stress. This can relate to cognitive immaturity, lack of judgement, impulsivity, and method availability (Oquendo & Mann, 2008).

Potential risk factors related to an increased risk of suicide in children

Individual factors

Children with psychiatric disorders have been found to be more likely to engage in suicidal behaviour, with suggestions that these disorders are present in up to 95% of child and adolescent suicides (Groholt & Ekeberg, 2003, cited by Soole, et al, 2014). Of course, mental health issues may be present and diagnosed, or not recognized and/or undiagnosed. For example, in the Soole et. al. (2014) study half of the children who died by suicide had known mental health and behavioural problems. Aboriginal and Torres Strait Islander children were less likely to have a mental health diagnosis. Suicide ideation and attempts in children with Autism Spectrum Disorder (ASD) has been found to be significantly higher than the norm and present across the autism spectrum. Suicide ideation and attempts in 791 children and young people aged 1 – 16 years with ASD was found in 14% of children in a study conducted in 2013 (Mayes, Gorman, Hillwig-Garcia, & Syed, 2013).

Attention Deficit Hyperactivity Disorder (ADHD) has been found to be associated with suicide, including deaths, suicide attempts, as well as thoughts of suicide. One-quarter of the children under the age of 12 years who displayed suicidal behaviour in a review conducted by Balazs and Kereszteny (2017) had ADHD.

Physical, emotional and/or sexual abuse of a child by a parent has been identified as perhaps the most predictive environmental risk factor for preadolescent suicide. Children who experienced abuse tend to "experience cognitive distortions, increased feelings of worthlessness, rejection, shame, guilt and responsibility for the abuse, emotional instability, greater levels of impulsivity, low self-esteem, and increased thoughts of suicide" (Westefeld, et. al., 2010).

It has been suggested that biological changes and fluctuations in mood during puberty may increase the risk for suicide as preadolescent's age, exit childhood and enter adolescence. This suggestion is supported by the greater number of suicide attempts and completions around the age of 11 and progressively increasing through the teenage years (Westefeld, et al., 2010).

The lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually and gender diverse (LGBTIQA+) adult population, despite limited research, has recently been identified as a group at risk of suicide, particularly when there has been a lack of acceptance by family and other stressors present (Skerrett, Kolves, & De Leo, 2017). While there is no research available at present specifically in relation to children identifying as LGBTIQA+, it is likely that this may be a risk factor for some children.

Family factors

Interpersonal and familial conflicts, in particular parent-child conflicts, have been identified as a predictive factor for child suicide and the most common life event related to suicide risk for both Indigenous and non-Indigenous children (Groholt, et al., 1998; Soole, Kolves & De Leo, 2014). As children are dependent upon adults for their basic needs and survival, family stress may negatively impact a child and influence him or her to consider, threaten or attempt suicide. They may also perceive themselves to be responsible for conflict and problems in the family and find it difficult to differentiate their own response to family stress from a sense of culpability. As a child's emotion regulation and problem-solving skills are not fully developed, suicide-related ideations and behaviour may emerge in efforts to escape or solve the problem as they see it (Pfeffer, 2000). Relationships with siblings may also be an important factor. Lower levels of support and understanding from siblings were reported by adolescents at high risk for suicide attempts compared to low-risk groups (de Wilde, Keinhorst, Diekstra, & Wolters, 1994).

A low level of parent-child communication was found to be a risk factor for suicide (Gould, Fisher, Parides, Florey & Shaffer, 1996, cited by Kolves, 2010). Samm, et al. (2010) found that school children may be protected against suicidal ideation when they perceive the possibility of talking about their worries with their mother and father to be easy.

Peer factors

Children who experience social isolation or alienation from their peers and/or a lack of social support are at an increased risk for suicidal behaviours (Westefeld, et al., 2010). Negative peer relationships, particularly the experience of being bullied, have been associated with suicide-related behaviours in several studies (Hawton & Harriss, 2008). The relationship between being bullied and suicide-related behaviours may be especially important in childhood. One study found more children than adolescents who presented with suicide-related communications, attempts, ideations and behaviours reported having been recently bullied (Sarkar, et al., 2010). In another study, both traditional bullying and cyber-bullying were associated with suicide-related thoughts and suicide attempts in a sample of almost 2,000 middle-schoolers (Hinduja & Patchin, 2010). Further, a meta-analysis related to bullying and suicidal ideation and behaviours conducted in 2014 found that involvement in bullying in any capacity is associated with suicidal ideation and behaviour in young people, although the authors noted that it is likely that bullying is only one factor among many that plays a role in youth suicidality. Other factors such as relationship problems, recent crises, mental health problems and dating partner problems are likely to be experienced at the same time as bullying (Holt, et al., 2014).

School factors

Children who experience academic problems or disciplinary problems with school authority figures have been found to be at increased risk for suicide (Westefeld, et al., 2010). Difficulties at school was found to be an area of recent difficulty reported by young people aged under 15 years presenting for treatment of suicide-related behaviour, with 37.9% of children and adolescents endorsing difficulty in academics (Hawton & Harriss, 2008).

Life events

Stressful life events impact children in much the same way as family dysfunction. In fact, the two categories overlap a great deal, because family dysfunction is inherently a stressful life event, and many stressful life events occur within the context of the family. A separate category for stressful life events is warranted, however, in order to emphasize certain types of stressful life events that have been found to particularly relevant to suicide risk and to capture the important cumulative effect of stressful life events across various domains of functioning.

Early chronic stress has been associated with child suicide-related behaviours (Pfeffer et al., 1993). Parental divorce or separation is a significant stressful life event that may play a role in childhood suicide-related behaviour. Frequent moves and changes in household are other life stressors that have been associated with suicide-related behaviour in youth (de Wilde, et al., 1994).

Precipitating events within the six months prior to suicide were identified in almost 80% of children; however, the type of events varied (Groholt, et al., 1998). Precipitating events included: childhood trauma; bereavement, familial problems, romantic and interpersonal relationship problems, somatic health issues, legal issues, school or work issues (including perceived or real performance difficulties); financial issues; homelessness; and events of transition (transition from primary to high school, or high school to employment, changing schools, moving interstate or a distance from home, etc.) (Soole, et al., 2014). Communication with parents may be more difficult when parental job migration forces children to leave their established social support network; they may feel lonely and withdrawn when adapting to a new environment, which may then make them more vulnerable to suicidal behaviours (Qun, Mortensen, & Pedersen, 2009, cited by Kolves, 2010).

Indigenous children who die by suicide have been found to be more likely to die outside the home, to be living outside the parental home at the time of death and be living in remote or very remote areas. Indigenous children were also found to consume alcohol more frequently before suicide, compared to other Australian children (Soole, Kolves & De Leo, 2014).

Protective factors

There is limited research explicitly looking at protective factors in relation to preventing children's suicide, although Westefeld, et al. (2010) identify four key factors which may serve to protect children from suicide:

(a) strong family relationships characterized by warmth and support and the absence of abuse or the identification and early treatment of abused children;

(b) early identification and treatment of children with psychological disorders, particularly depression;

(c) postvention efforts that reduce contagion following suicide; and

(d) information made widely available to parents, teachers, school administrators and mental health providers to reduce the risk of adults dismissing early warning signs due to the intuitive inconsistency between children and suicide.

It could also be argued that protective factors identified to support positive children's mental health more broadly also apply to suicide prevention for children.

These include:

Individual factors

• easy temperament • adequate nutrition • attachment to family • above-average intelligence • school achievement • problem solving skills • internal locus of control • social competence • social skills • good coping style • optimism • moral beliefs • values • positive self-related cognitions

Family factors

• supportive caring parents • family harmony • secure and stable family • small family size • more than two years between siblings • responsibility within the family (for child or adult) • supportive relationship with other adult (for a child or adult) • strong family norms and morality

School context

• sense of belonging • positive school climate • prosocial peer group • required responsibility and helpfulness • opportunities for some success and recognition of achievement • school norms against violence

Life events and situations

• involvement with significant other person (partner/ment or) • availability of opportunities at critical turning points or major life transitions • economic security • good physical health

Community and cultural factors

• sense of connectedness • attachment to and networks within the community • participation in church or other community group • strong cultural identity and ethnic pride • access to support services • community/ cultural norms against violence (Commonwealth of Australia, 2000, p. 15).

Warning signs

While risk factors may be present in children who are more likely to be suicidal, they do not in themselves predict actual risk and of course many children with those risk factors do not become suicidal. Warning signs are not always apparent in children and in fact previous suicide attempts are one of the strongest predictors of adolescent suicide but this is not necessarily the case in younger children. This highlights the danger of underestimating the intensity of children's emotions and seriousness of suicidal expression or behaviour (McGuire, 1982, cited by Soole et al, 2014) and emphasises the importance of taking all suicidal communication by children and adolescents seriously. It is also possible that children do not express suicidal ideation prior to attempting suicide or adults do not pick up on the thoughts and behaviours suggesting suicidal ideation.

Methods of suicide by children

Children have been found to report realistic and varied methods of suicide (Mishara, 1998, cited by Soole, et. al., 2014). Methods such as jumping from a height, running into traffic, or self-poisoning, if used by children, could be recorded as accidents (Groholt & Ekeberg, 2003, cited by Soole et al, 2014). Methods perceived by adults to be tragic accidents have been found to be methods suggested by children as potential means to end one's life (Mishara, 1998, cited by Soole, et al., 2014).

It has been shown that it is easy to find information about suicide methods on the internet and people use the internet and media as the main information sources about suicide methods, as shown among near-fatal suicide attempters. Children and young people can learn about suicide from the media and internet and are therefore most exposed (Dunlop, More, & Romer, 2011).

Role of teachers and school staff

Teachers are key people in the lives of primary school children and research conducted in 2014 of 115 teachers in Queensland primary and secondary schools provides insight into teachers' perspectives about suicide and their suicide prevention role in schools. In the 2014 research, five key themes were identified as follows:

1. awareness and stigma reduction;
2. education and training in suicide prevention;
3. support services for students;
4. bullying (students who are different: LGBTIQA+, overweight);
5. role of social media

(Ross, Kolves & De Leo, 2017)

Given the significant role that primary school teachers play in the lives of children they work with and their families on a day to day basis, it is possible that the role of "gatekeeper" as identified in literature (e.g. Gvion & Apter, 2016) insufficiently describes the source of support through relationship development and building of trust that the teacher provides for primary school aged children and their families.

School interventions to support children, families and staff members

While there is a growing body of literature in relation to school interventions (e.g. Gvion & Apter, 2016) to support adolescents, some of which relate to suicide-specific education, most of the interventions have not been developed for, or trialed in, primary schools. Accordingly, the following suggestions are based on responses that take into account the suicide risk factors identified above for primary school aged children.

Primary prevention – universal

Schools strive to maintain a safe and supportive environment where student mental health and wellbeing is considered a priority and students feel comfortable sharing concerns. This type of environment would not only enhance social-emotional development but it would also serve to optimise learning outcomes. The actions a school takes in this regard serve as resilience building and preventative. Prevention of [youth] suicide can thus be addressed where students spend a significant part of their day – at school (Gostelow, Poland, Guedj, & Seth, 2017, p. 291).

Primary prevention responses include:

– Universal social and emotional learning programs to teach communication skills, coping skills and problem-solving skills
– Promoting positive relationships and effective responses to bullying
– Promoting help-seeking by children and families when concerns arise

Targeted responses to 'at risk' students - Having clear referral pathways for mental health assessment and treatment when behaviours of concern are noticed

Schools are considered to be excellent places for monitoring changes in individual student wellbeing, identifying emerging problems and partnering with parents/guardians and inter-agency colleagues to provide support. Knowing what to look out for, and having clear internal and external referral pathways will ensure that school staff are well-equipped to respond quickly and confidently when they notice changes in students.

If a child dies by suicide – postvention responses

When a suicide of a child occurs, schools are ideally placed to provide support to all those affected and protect the wellbeing of students and staff. The death will impact the whole school community and responses which promote positive coping strategies and access to mental health professionals when required will be necessary.

A child dying by suicide can be defined as a traumatic event requiring a critical incident or emergency management response at the child's school. This response will vary to ensure that it takes into account the specific circumstances but typically includes:

(a)   immediate emergency responses (as required),

(b)   gathering accurate information and gaining agreement on information to be shared with the community, and

(c)   identifying those community members who may require support.

In the immediate aftermath of a traumatic event in schools and communities, the most effective primary prevention intervention is currently considered to be Psychological First Aid. The Psychological First Aid intervention will need to be tailored as required and may be implemented by school psychologists, other mental health staff or education staff who have received training and are sufficiently removed from the direct impact of the event.

Conclusion

Death of children by suicide is a rare event, however, it has been recognized for some time that it can occur. While research in relation to suicide by children is limited, there are indications of ways that families, schools, health and community professionals can be supported to become more aware of risk and protective factors which may help to increase understandings about children at risk and warning signs which may be indicators that a child needs support. Building protective factors within families, schools and communities are important preventative measures. However, more specific actions which support effective communication between children and adults, particularly during times of conflict and stress at home, school or in the community; early recognition and intervention for emerging mental health difficulties; and culturally appropriate support for families, seem to be critical factors in reducing suicide risk in children. In the event that a suicide does occur, appropriate postvention supports are essential to support the whole school community.

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