Suicide among Children and Adolescents in Thailand

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พฤติกรรมฆ่าตัวตายหมายถึงการทำร้ายตนเองที่มีผลให้เกิดอันตรายต่อตนเอง ซึ่งมีข้อถกเถียงเกี่ยวกับประเด็นการฆ่าตัวตายในเด็กเนื่องจากพัฒนาการทางสติปัญญาของเด็กมีข้อจำกัดในเรื่องความเข้าใจเกี่ยวกับการตาย เด็กเล็กคิดว่าตนเองเป็นจุดศูนย์กลางของจักรวาล เด็กอาจปรารถนาที่จะตายเขาคิดว่าถ้าเขากินยาเกินขนาด จะทำให้เขาตายเหมือนกับการนอนหลับ นักทฤษฎีบางคนมีความเห็นตรงข้ามว่าเด็กไม่ได้ฆ่าตัวตายหากว่าเขาไม่เข้าใจความหมายของคำว่าตาย แต่ข้อสรุปนี้อาจไม่ถูกต้องเพราะพฤติกรรมทำร้ายตนเองนั้นเป็นผลจากการที่เด็กตั้งใจฆ่าตัวตาย

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คำสำคัญ : การฆ่าตัวตาย, เด็กและวัยรุ่น, ปัจจัย

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Abstract

Suicide behavior is defined as any self destructive act in which a person intend to kill him or herself. There are some debating issues about suicide in young person.. According to Piaget's cognitive level of children, concepts of death in very young person are premature. Younger children think in egocentric term. Suicidal children may wish to die and think that if they overdose of sedatives it will make them die but the concept of death is to go to sleep. Some assumed that children might not be considered to be suicide if they do not understand that death is final. But this assumption should be wrong because self destructive behavior has been observed as an outcome of children's intent to kill themselves.

This paper reviews suicide in area of epidemiology, methods of suicide, and associated factors with suicide, repetitive suicide, and suicide prevention.

keywords : suicide, children and adolescents factors

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Introduction

Suicidal behavior is defined as any self-destructive act in which a person intends to kill him or herself.[1] Issues still being debated about suicide in young persons. According to Piaget's cognitive levels of children, the concepts of death in the very young is premature. Younger children think primarily in egocentric terms. Suicidal children may wish to 'die' and think that if they overdose of sedatives it will make them die, but their concept of death is not very different than going to sleep. Some psychiatrists have assumed that children might not be considered suicidal if they do not understand that death is final, but this is wrong because self-destructive behavior has been observed as an outcome of children's intent to kill themselves.[2]

The concepts of suicidal behavior in children and adolescent includes thoughts about causing intentional self-injury or death(suicidal ideas) and acts that cause intentional self-injury (suicide attempt) or death(suicide).[3] This paper reviews suicide in the areas of epidemiology, methods of suicide, associated factors with suicide, repetitive suicide, and suicide prevention.

Epidemiology

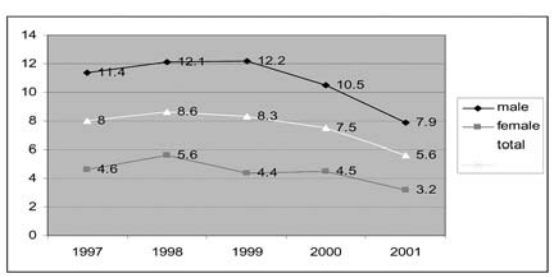
The suicide rate among Thai people of all ages was 6.9 per 100,000 in 2004[4] (7.8 per 100,000 in 2002). This is in the middle range compared to other countries ranges from 1.1 (1.8:05 male: female) in Azerbaijan by the year 2002 to 42.1 (74.3:13.9 male: female ratio) in Lithuania by the year 2003[5] The most notable feature of the Thai figures is the high suicide rate for Thai males, with a mean rate of 9.0 per 100,000, compared to 4.5 per 100,000 for females. The rate of suicide in males is also increasing considerably, from 7.6 per 100,000 in 1980 to 12.0 in 2002[6] In younger people the rate is 0.5-1.2 per 100,000 among 10-14-year-olds and 5.6-8.3 per 100,000 among 15-19-year-olds[7] Early young adults aged 25-29 has a highest suicide rate of all ages (Table1) (Figure1).

Table 1 Suicide Rates distributed by sex and age

Year	10-14 years.			15-19 years.			20-24 years			25-29 years		
	M	F	T	M	F	T	M	F	T	M	F	T
1997	0.0	0.0	0.0	11.4	4.6	8.0	18.4	4.9	11.7	19.2	4.9	12.1
1998	1.4	0.9	1.2	12.1	5.6	8.6	21.7	5.1	14.6	23.9	5.2	13.5
1999	1.4	0.7	1.1	12.2	4.4	8.3	21.5	5.6	13.6	25.9	5.8	15.9
2000	0.0	0.0	0.0	10.5	4.5	7.5	22.9	4.3	13.6	25.3	4.6	15.0
2001	1.0	0	0.5	7.9	3.2	5.6	19.7	4.3	12.0	21.6	4.8	23.2

* From Strategy and Planning Division, Ministry of Public Health, Thailand,{2002-2003}

Figure 1 Suicide rates among adolescent aged 15-19 years during1980-2002.



* From Strategy and Planning Division, Ministry of Public Health, Thailand,{2002-2003}

Little information is available on suicide in children under 15 years of age in Thailand. Suicide, exceedingly rare before puberty, becomes increasingly frequent through adolescence.[6,7] Suicide is much more common in adolescent and young adult males than females (the ratio grows from 2- 3:1 in the rare pre-puberty suicides to approximately 3-5:1 in 15-24 year-olds.[6] The rates were similar to other countries.[8,9] Attempted

suicide, parasuicide, is at least ten times more common than suicide. Attempted suicide is relatively rare under 12 years of age.[10]

There have been a few recent studies examining suicide in Thai youths. The national youth depression and suicide survey used a multi-stage sampling design, in which 4,885 adolescents aged 15-19 were asked specific questions about suicide. The study found that 13.0% of adolescents reported that they had suicidal ideas; 8.9% had a specific plan, and 6.8 % had actually attempted suicide.[11] Another study, based on the modified Youth Risk Behavior Survey Questionnaire[11] was conducted among adolescents in the Bangkok Metropolitan area. The main risk behaviors noted in 2,311 adolescents aged 10-18 years were never using a helmet while motorcycling (50.1%); never fastening a safety belt (30.6%); driving after drinking (1.0%); fighting (31.5%); sexual relationship without using a condom (7.1%). Among the same group there were depressive symptoms (19.9%); suicidal idea (12.0%); having had a suicide plan (15.9%); having made a suicide attempt (8.0%); a suicide attempt requiring medical treatment (1.7%).[12]

In the multicenter data collection in Thailand, there were 1,329 suicide attempts with 61 successful. Of the suicide attempts, 14.7% had made a plan, 22.3% had a previous suicide attempt ,40.0% had depressive symptoms, 20.0% had psychotic symptoms, and 74.0% still wished to die after discharge. Among the young suicide attempters (age 15-19 years) more than half were married. Referral for treatment is more common in females than in males (sex ratio 2:1), although the success rate in suicide attempts is reversed, 1:2 female to male.[13]

Similarly, a national youth risk behavior survey in the US found that 19.3% of high school students reported that they had seriously thought about attempted suicide, 14.5% had a specific plan, 8.3% had actually attempted suicide, and 2.6% had made a suicide attempt that required medical attention. Females were significantly more likely than males to suicidal idea (24.9% VS 13.7%) or to have significant plans (10.9 VS 5.7%). 2.5% of females and 1.6% of males had made a suicide attempt requiring medical attention but this difference was not statistically significant.[14]

Methods of suicide

The common methods used by adolescent to commit suicide in Thailand are hanging, herbicide ingestion, and firearms. For all ages, hanging is the most commonly used method of committing suicide.[6,13] Among Asian countries, the most common methods of committed suicide are drug overdose or poison intoxication, hanging and jumping from a height. In Hong Kong, jumping from a height was the most common method since there are lots of high buildings.[15]

Peracetamol is often used since this drug is available and young people unaware of the dangerousness of overdosing with paracetamol. At least half of the young suicide attempters were overdoses with paracetamol.[16] Intentional overdoses or deliberate self-injury subjects were the most common reason for acute hospital admission among adolescent women. The proportion of subjects who had attempted to kill themselves with paracetamol, psychiatric drugs, herbicides, and detergents were 24.4%, 21.3%, 17.7%,17.5% respectively.[16]

Risk factors

1. Predisposing Factors

Predisposing psychiatric conditions, such as depression, disruptive disorder, or anxiety etc, are important risk factors for suicidal behavior or other risky behaviors in adolescents.[17,18] Data from an epidemiology (of child and adolescent Mental Disorders) study of 1,285 randomly selected children and adolescents aged 9-17 years were analyzed with respect to suicide ideation and attempts, psychiatric diagnosis and psychological risk factors, and found that mood, anxiety, and substance abuse / dependence disorders independently increased the risk for suicide attempts.19 Mood disorders in children and adolescents are also associated with increased disruptive diagnoses.[20]

Teen suicide attempters are much more likely than those who have only suicidal idea to have associated psychopathology, especially a mood disorder, but the attempt often occurs in the context of a relatively brief adjustment reaction.[21] Among suicide attempters, there were more impulsive and instable mood.[22]

Besides systematically studied risk factors for attempted and completed suicide in adolescents, other important personality and psychological risk factors may be the precipitating cause of a suicide attempt. Apter described 2 types of suicidal behavior in adolescent inpatients, the first characterized by a wish to die and common in depressive disorders, the second characterized by impulsive control problems and associated with externalizing disorders.[23]

In completed suicides, most studies using psychological autopsy methods have consistently found that approximately 90% of youths who commit suicide suffer from psychiatric disorders at the time of their deaths.[24] Mood disorder, especially major depressive disorder, was reported to be the most prevalent psychiatric disorder among the youth suicide victims.[25,26,27] More than half had suffered from a psychiatric disorder for at least 2 years.[28]

Family factors

Lack of family studies about suicide among children and adolescents in Thailand, most of data represented the studies from other countries. There have been several family studies that have compared the risk for suicide or suicide attempt in first-degree relatives of probands who have completed suicide compared to the rate among relatives of control probands. Gould et al. (1996), in a family study, reported a greater than fourfold excess of suicidal behaviors in the relatives of 120 adolescent suicide victims compared to 147 community controls, which persisted even after adjusting for other significant family risk factors.[29]

Brent also found that there was a two-fold excess of first-degree relatives of completers with suicidal idea, although the difference was not significant after controlling for the rate of psychopathology.[30] Many studies have also reported a higher risk for suicide attempt or completion in relatives of adolescent attempters compared to relatives of controls.[31]

Psychosocial factors

Holinger (1979) postulated a **"**continuum of destructiveness**"** in adolescents ranging from covert (e.g. substance use, unprotected and precocious sexual activities, reckless driving) through overt (e.g., self-mutilation and suicide attempts).[32]

A youth risk-behavior survey in Bangkok found that psychological factors related to suicide were poor relationship with parent (RR 3.84,95% CI 2.17-6.8); having problems with peers (RR1.93, 95% CI 1.18-3.5); no psychological support (RR 1.83, 95% CI 1.03-3.23); and academic failure for depression (RR 2.23, 95% CI 1.08-4.61).[12]

Using data for high school students in the USA, researchers found that suicide attempts in males were significantly associated with physical fights resulting in injury, regular tobacco use, gun carrying, substance use before recent sexual activities, and drug use, multiple sexual partners, low - academic performance, antisocial behavior and substance use were associated with self harm in girls.[33,34,35]

In another study in Australia, sexual activities were independently associated with deliberate self-harm in both sexes in Australian high school students[36] In the same study, youth suicide attempters and showed a strong association with aggression and mood disorder.

Reasons for suicide attempts

The factors triggering a suicide attempt were often related to an acute relationship problem with a parent or parents and/or a romantic partner.[12] Parent-child conflict was a more common precipitant for younger adolescent victims, whereas romantic difficulties were common in older adolescents.[37] A quarrel with a parent, or a break-up with a boy- or girl-friend could spark fury and despair that resonates with losses and disappointment. Another immediate reason often cited was academic failure. Fully one-third of adolescents who make a serious suicide attempt, however, were unable to describe any precipitating factors.[22]

Suicidal action often took place shortly after a stressful event (disciplinary crisis, fight with parent or romantic partner) induced some extreme emotion such as depression, rage, or hopelessness, but could also follow a distorted emotional feeling arising from a depressed mood or intoxication with drugs and/or alcohol.[38]

Repetitive suicide attempts

Hospital based survey in suicide high risk areas, the study found that 26.2 % of suicide attempters had previous suicide attempted.38 Another hospital-based data from one study showed that 22.3% of suicide attempters, and 8.2% of completers, had previously attempted suicide.[13]

Goldacre & Hawton have suggested that adolescents are at a greater risk for re-attempting during the first few months following an initial attempt.[40] The majority of youngsters who repeated their suicide attempts within the first year did so during the first few months after the index episode. Many researchers have found a higher repeated-attempt suicide rate among adolescents aged 13-18 year referred for treatment at - 7 years following an initial attempt compare to 1 year; of attempters(32% VS 15 %); of ideators (21% VS 15%); and of young people receiving psychiatric treatment (12% VS 2%).[41,42]

Suicide prevention

Suicide-prone youths are often impulsive, they may be ambivalent about killing themselves, and the risk period for actual suicide is transient.[43] Restricting access to lethal methods during this period may prevent suicide. Restriction on guns has been associated with a decreased suicide rate in some studies.[44]

Because Asian people often use herbicide or poisoning agents to kill themselves, perhaps restrictions on these chemicals might be an idea to reduce the suicide rate. The Department of Mental Health has had a training program for primary physicians for many years to screen for potential suicide attempters. The physicians are taught the warning signs of suicide, treatment using clinical practice guidelines and referral pathways to direct the suicide patient to a tertiary psychiatric hospital. Also, school mental health and/or surveillance programs have been launched in order to identify at-risk students. A profiling questionnaire (the Strength and Difficulty Questionnaire) is one tool used for high school students which can identify those requiring professional mental health services.[45,46,47]

Suicide is an emergency problem. Telephone counseling is provided by at least 17 psychiatric hospitals of the department of Mental Health for people facing a crisis. But the utilization of hotlines for counseling among teenagers is very low. Most youngsters call D.J at radio station when they are in distress. The Department of Mental Health has provided several training courses for D.J.s to recognize signs of depression and some psychotic symptoms; to refer at-risk cases and to know the referral pathway to an appropriate hospital in their area; and to practice some counseling techniques.[45] In some areas, special child-lines have been set-up for abused children and adolescents, include suicidal cases, by local NGOs.

According to evidence for "suicide contagion", young people may imitate a suicidal act after seeing a sensational picture. Media professionals could reduce this phenomenon by avoiding headlines, pictures or text about suicide on the front page of newspapers, television scenes of suicide attempts, and so on. To help media people understand this problem, the Department of Mental Health has arranged for psychiatrists to meet with people in the press and discuss mental health literacy.

Conclusion

The suicide mortality rate for 15-19 years old is 5.6-8.6 per 100,000, five to eight times the rate of the younger age group. There was few studies about suicide prevalence and associated factors among children and adolescents in Thailand. Suicide studies and Monitoring by youth risk behavior survey should be done regularly for suicide prevention and management. The youth attempter or completer has the dangerous confluence of trait-dependent vulnerability factors (e.g. impulsivity, poor interpersonal coping skills, aggressiveness), additional triggering stressors including intense dysphoric affects, together with permissive factors (e.g. contagion effects, lack of social support) and the concurrent availability of lethal means.

Clinical experience suggests that there are youngster with severe depression or psychosis who may be prone to attempt suicide to escape intolerable psychic pain, even without much additional contribution from negative family or life events, substance use, or other problem behaviors; indeed, such youngsters' families may be intact and supportive.[48] Suicide prevention should focus on encouraging alternative methods of managing distress such as problem solving and help seeking; restriction of poisons and firearms; making crisis hotlines more widely available and used; training programs for primary physicians and gatekeepers at the first time you use the patient; and media education.[49]

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