Suicidal thoughts and acts in Irish adolescents

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Abstract

Objectives: To determine the frequency of reported suicidal thoughts and acts in (a) a school-based sample of Irish adolescents, (b) adolescents attending a community child and family mental health service.

Method: The study population consisted of: (a) 195 adolescents aged 13-15 years attending ten secondary schools throughout Ireland. The schools were selected to represent a wide social and cultural spread: and (b) 66 adolescents aged 13-15 years attending a community child mental health service. The measures used were the Child Behaviour Checklist completed by the parents of the adolescents and the Youth Self Report completed by the adolescents.

Results: Within the school sample, the parents of 3% of adolescents reported that their child had talked of harming him/herself, but none reported acts of self-harm. Fifteen percent of the adolescents themselves reported that they had thoughts of harming or killing themselves, and 8% reported that they had tried to harm or kill themselves. Within the mental health clinic attenders sample, the parents of 33% of the adolescents reported that their child had talked of harming him/herself, and the parents of 27% reported that their child had tried to harm or kill themselves. Twenty-one percent of the adolescents themselves reported that they had thoughts of harming or killing themselves, and 21% percent reported that they had tried to do so. In both groups, adolescents with higher total problem, internalising and externalising scores on the questionnaires, indicating greater disturbance, were more likely to report thoughts and acts of self harm.

Conclusions: Thoughts of suicide and acts of self harm are common in Irish adolescents and are not limited to those attending mental health services. Parents are frequently unaware of these thoughts. Further studies involving interviews with adolescents at risk are indicated to determine the significance of these thoughts and how adolescents deal with them.

Key words: Suicide; Self harm; Children; Adolescents.

Introduction

Rates of suicide have risen sharply in Ireland as in most westernised cultures in the past 10 years. The rise is particularly marked in young men in the 15-24 year age range. Suicide is now the leading cause of death in this age group, with a rate of 19.5 per 100,000 per year in Ireland.[1] Of the 413 people who committed suicide in the Republic of Ireland in 2000, 109 (26%) were under 24 years of age, the majority being young men.[2]

Little is known about the mental health needs of young people in Ireland. Suicidal acts, depressive disorders and social exclusion are known to be risk factors for future suicide but few young people with these risk factors are in contact with medical or mental health services,[3,4] The National Task Force Report on Suicide recommended that empirical field research should be done to determine risk factors and to provide essential information prior to the setting up and evaluation of a national suicide prevention policy.[1]

Moscicki describes a continuum of severity of suicidal behaviours, "from less serious and more prevalent behaviours through increasingly severe and less prevalent behaviours".[5] These behaviours range from fairly common suicidal thoughts to relatively rare lethal attempts and completions. Increasing numbers or severity of risk factors may predict more severe outcomes. Studies of community samples of adolescents in the USA have shown that suicidal thoughts are relatively common, occurring in 27% of adolescents over a one year period in the large Centers for Disease Control study of 11, 000 high school students.[6] Another large US community based study found that almost 30% of adolescents reported suicidal thoughts.[7] Rates of reported suicidal attempts are much lower, ranging from 8% in the former study to just below 2% in the latter study. An Irish study of 88 adolescents attending four Dublin secondary schools showed rates of suicidal thoughts and acts similar to those reported in the USA.[8] A recent Irish community-based study of school going adolescents aged 15-17 years showed that 6% of adolescents thought of suicide frequently and 17% thought of it occasionally.[9] The WHO/EURO Multicentre Study of Parasuicide showed a huge variation in rates of self-harm between European countries and between regions in the same country.[10] This may be due to differences in definition, but it makes comparisons impossible.

The present study was undertaken to provide further information about rates of suicidal thoughts and acts of self-harm in a broad spectrum of Irish adolescents, to look at urban/rural differences, and to determine whether parents were aware of these thoughts in their children. Such information is essential before interventions to reduce suicidal behaviours can be planned and evaluated.[11,12]

Method

The study population consisted of:

- a community school-based sample

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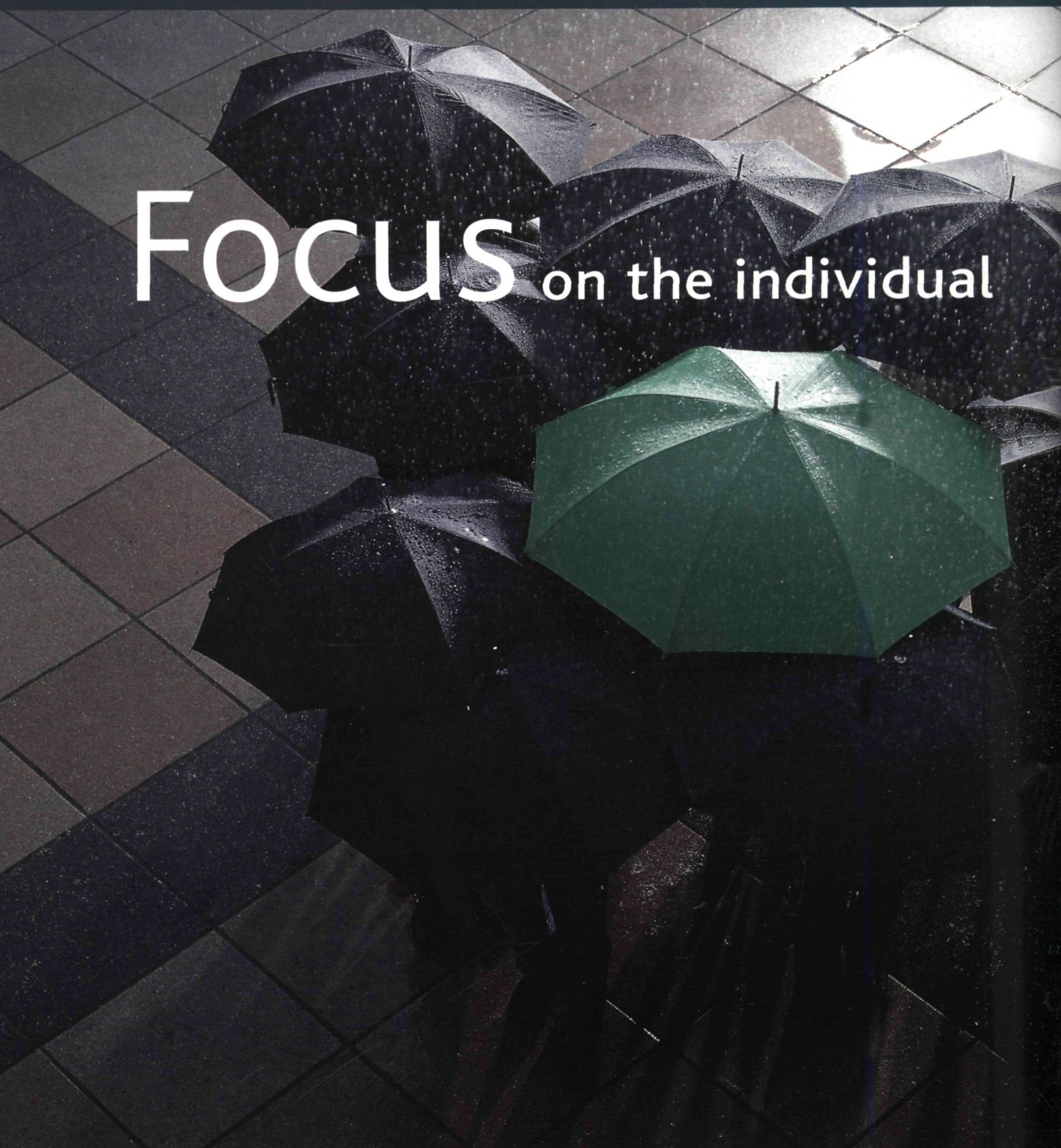

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Table 1: **Suicidal thoughts and acts**

(N)	Informant	Thoughts N (%)	Acts N (%)
School sample			
(195)	Parent CBCL	6 (3%) (95% CI 1.1%-6.6%)	0 (0%) (Upper 95% CI 1.9%)
	Adolescent YSR	30 (15%) (95% CI 10.6%-21.2%)	15(8%) (95% CI 4.3% - 12.4%)
Mental health service attenders			
(66)	Parent CBCL	22 (33%) (95% CI 22.2%-46%)	18 (27%) (95% CI 17% - 39.6%)
	Adolescent YSR	14 (21%) (95% CI 12.1% - 33%)	14 (21%) (95% CI 12.1% - 33%)

CBCL: Child Behaviour Checklist
YSR: Youth Self Report

- a sample of adolescents attending mental health services.

In order to achieve a wide and representative sample of Irish school children, 12 schools were selected throughout Ireland, on the basis of their geographical location to reflect population distribution in both urban and rural settings. Urban schools were those in Dublin, Cork, Limerick and Galway – the largest cities in the Irish Republic where approximately two thirds of the population live. Rural schools were those in or near small towns. Both single sex and coeducational secondary schools were included.

The school principals of eight schools (five urban and three rural) were approached and five agreed to participate. The three non-participating schools (two urban and one rural) did not give any reason for their decision, and we were unaware of any differences between them and the eight participating schools. All pupils aged 13-15 years in the secondary schools formed the study population (n = 278).

The sample of adolescents attending mental health services comprised 60 consecutive new attenders aged 13-15 years at a community-based child and adolescent mental health service, recruited over a six month period, and 31 adolescents attending the service's special school for young people with significant emotional, behavioural or communication problems.

The measures used were the Child Behaviour Checklist (CBCL) and the Youth Self Report (YSR). These measures are widely used in child mental health as screening instruments. Originating in the USA, they were standardised on American young people in the late 1970s and early 1980s. They were re-standardised in the late 1980s, with norms being published in the Manual for the Child Behaviour Checklist 4-18 and 1991 Profile, and the Manual for the Youth Self Report and 1991 Profile.[13,14] Parents completed the CBCL about their children, and adolescents independently complete the YSR about themselves. Both are detailed questionnaires which take about 20-30 minutes to complete. They cover the young person's areas of strength (competencies), as well as emotional and behavioural problems.

Scoring of the questionnaires yields a number of results which fall into four broad categories:

- Competence score

Table 2: **Relationship between suicidal thoughts and acts and total problem scores**

	Total problem score (Youth Self Report) N	Mean	(SD)
School sample			
Thoughts of self-harm			
Absent	165	34.2	(19.3)
Present	30	63.9	(20.2)*
Acts of self-harm			
Absent	181	36.7	(21.1)
Present	14	65.6	(18.7)*
Mental health service attenders			
Thoughts of self-harm			
Absent	53	41.2	(22.0)
Present	13	83.1	(17.3)*
Acts of self-harm			
Absent	53	41.9	(22.7)
Present	13	80.2	(20.2)*

**t-tests for all differences in means are significant at p < 0.001*

- Internalising problems score (withdrawn, somatic complaints, anxious/depressed)
- Externalising problems score (delinquent and aggressive behaviour)
- Total problem score.

The results can be plotted in graph form giving a useful visual image of the young person's strengths and problem areas.

In addition to total problem scores we were particularly interested in two items on the CBCL: *'Deliberately harms self or attempts suicide'* and *'Talks about killing self'* and two items on the YSR: *'I deliberately try to hurt or kill myself'* and *'I think about killing myself.'*

Each of these items can be answered 'not true', 'somewhat or sometimes true', or 'very true or often true', scoring 0, 1 or 2 respectively.

Having received Ethics Committee approval, all parents were sent the CBCL and the YSR with a letter explaining that we wished to gain information about the behaviour and development of Irish young people. The parents were asked to complete the CBCL themselves and to encourage their son/daughter to complete the YSR independently without help from parents. All respondents were asked to give only the adolescent's date of birth, sex, parent's occupation and area of residence on the CBCL and YSR, and to return them in sealed envelopes to the researchers. These measures were taken in an attempt to reassure participants of the confidentiality of the study and of its independence from the schools and mental health teams.

Results

The samples

In the school sample there were 278 pupils aged 13-15 years from whom 195 completed CBCL and YSR were received (response rate of 70%). Of the 91 cases in the mental health service attenders sample, completed questionnaires were received from 66 (response rate of 72%).

from isolation...

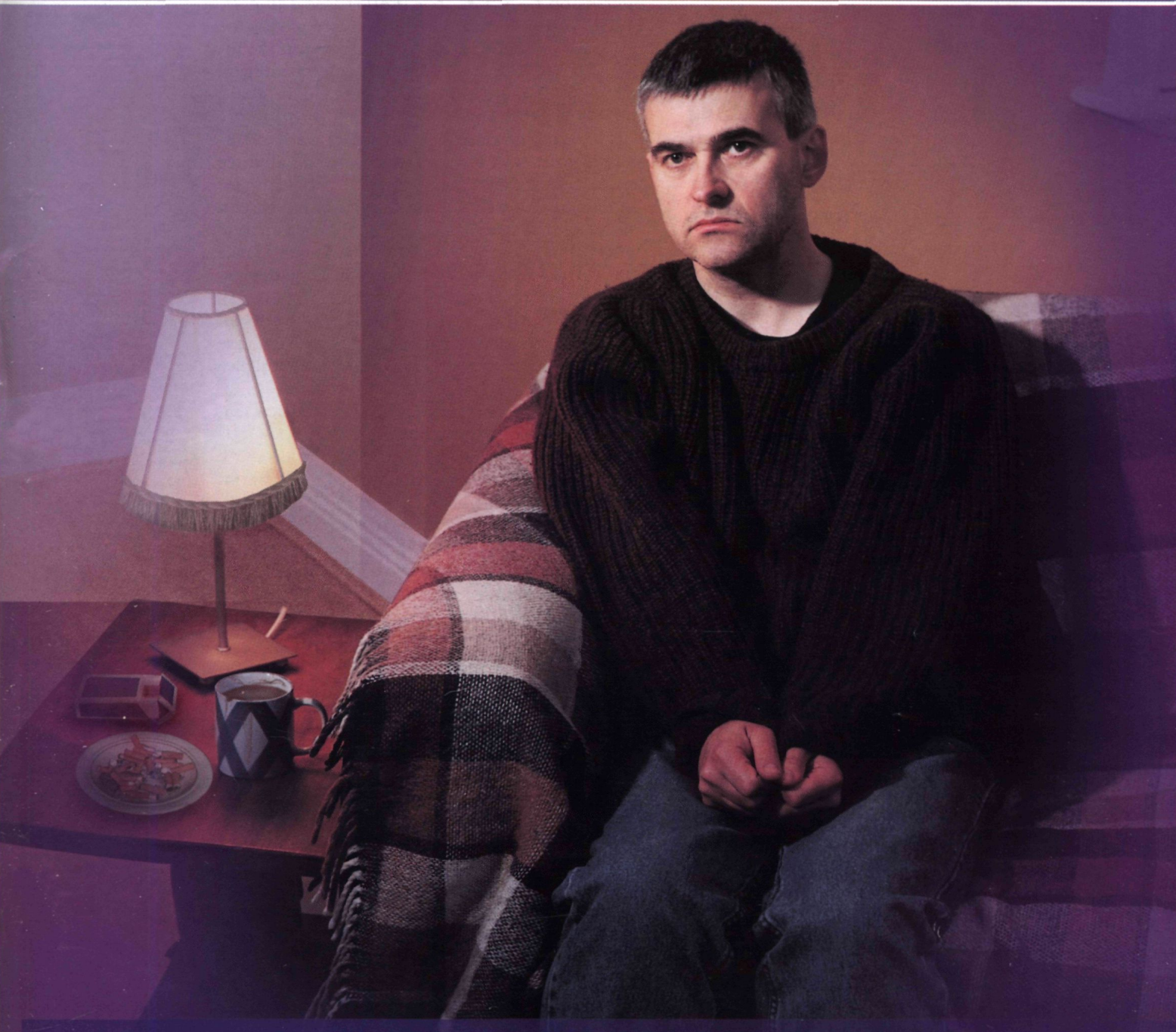

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Table 3: **Relationship between suicidal thoughts and acts and internalising and externalising scores**

	N	Internalising Mean (SD)	Externalising Mean (SD)
School sample			
Thoughts of self-harm			
Absent	165	10.7 (7.2)	10.5 (6.6)
Present	30	22.0 (8.4)*	18.8 (8.7)*
Acts of self-harm			
Absent	181	11.7 (8.0)	10.9 (6.8)
Present	14	21.2 (8.4)*	22.3 (8)*
Mental health service attenders			
Thoughts of self-harm			
Absent	53	13.4 (8.4)	11.6 (8.0)
Present	13	29.5 (9.2)*	23.5 (8.5)*
Acts of self-harm			
Absent	53	13.6 (8.5)	11.8 (8.4)
Present	13	28.5 10.6)*	22.5 (8.1)*

t-tests for all differences in means are significant at $p < 0.001$

Reports from parents and adolescents

Within the school sample, the parents of 3% of adolescents reported that their child had talked of harming him/herself, but none reported acts of self harm. Fifteen percent of the adolescents themselves reported that they had thoughts of harming or killing themselves, and 8% reported that they had tried to harm or kill themselves *(Table 1)*.

Within the mental health clinic attenders sample, the parents of 33% of the adolescents reported that their child had talked of harming him/herself, and 27% reported that their child had tried to harm or kill themselves. Twenty one percent of the adolescents themselves reported that they had thoughts of harming or killing themselves, and 21% reported that they had tried to do so *(Table 1)*.

Parents of adolescents attending child mental health services were significantly more likely than parents of the school sample to report that their adolescents had thoughts of self-harm (33% v 3%, df = 1, $p < 0.001$, Fisher's Exact), or had tried to harm themselves (27% v 0%, df = 1, $p < 0.001$, Fisher's Exact). Among the adolescents themselves, thoughts of self-harm were almost as common in the school sample as in those attending mental health services (15% v 21%, ns), but reported acts of self-harm were significantly more common in those attending mental health services (8% v 21%, df = 1, $p < 0.01$, Fisher's Exact).

Relationship between reports of self-harm and total problem, internalising and externalising scores

There was a strongly positive relationship between total problem, internalising and externalising scores on the YSR (indicating greater level of disturbance) and reporting thoughts/acts of self-harm. Adolescents who reported that they had thoughts of self-harm or that they had tried to harm themselves had significantly higher scores on the YSR than those without such reports *(Tables 2 and 3)*. A total problem score of > 67 on the YSR is considered to be in the clinical range. The mean total problem score for those adolescents with thoughts of self-harm, or who reported acts of self-harm (scoring 1 or 2 on the 0, 1 or 2 menu) in the school sample, approached the clinical range; while in the mental health service attenders sample the score was within the clinical range *(Table 2)*.

Gender differences

Two thirds of the school sample were female (M:F = 59:136, 70% female), while only one third of the mental health service attenders were female (M:F = 45:21, 32% female).

Within the school sample, more girls reported thoughts of self-harm than boys (17% v 12%, OR 0.66, 95% CI 0.22-1.7), while more boys than girls reported acts of self-harm (14% v 5%, OR 2.89, 95% CI 0.86-9.84) *(Table 4)*.

In contrast, within the mental health service attenders, more girls than boys (40% v 13%, OR 0.25, 95% CI 0.60-1.02) reported both thoughts and acts of self-harm *(Table 4)*.

Urban/rural differences

Urban/rural differences were looked at in the school sample only, as all the mental health attenders were from an urban background. There were no significant urban/rural differences in parent reports of thoughts (OR 2.8, 95% CI 0.30-134.8), or acts of self-harm in their adolescents, but thoughts of harming or killing themselves were reported by significantly more urban than rural adolescents (22% v. 4%, OR 6.0, 95% CI 1.7-31.8), as were acts of self-harm (11% v. 1.5%, OR 8.4, 95% CI 1.2-362.5).

There was no relationship between thoughts or acts of self-harm and social class.

Discussion

This study showed that thoughts and acts of self-harm were common in Irish adolescents in the community, and were particularly common in those attending mental health services. Parents of adolescents attending mental health services were very aware of these thoughts and acts in their adolescents, but parents of adolescents in the community were frequently unaware of these thoughts and acts. Those adolescents with thoughts and acts of self-harm were rated by themselves and their parents as having high rates of emotional and behavioural problems. Acts of self-harm were reported by significantly more boys than girls in the community school-based sample, although studies consistently show that more girls than boys present for treatment of self-harm.[6]

A number of features of the study sample and method need to be considered in order to assess

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its strengths and limitations. The schools were chosen on a geographical basis to represent population distribution. The sample was not random and thus some bias was possible. Also, as a school-based study, some of the most vulnerable adolescents may not have been included. Many studies have shown high drop-out rates in early secondary school, and among those registered as school attenders a number will be absent on any one day. The drop-outs and absent adolescents are likely to be a particularly vulnerable group with high levels of emotional and behavioural problems.[15,16] It is likely that our results from the school-based sample under-represent levels of thoughts and acts of self-harm in adolescents.

This study had insufficient statistical power to detect a number of the possible differences sought. Many of the associations reported had wide confidence intervals, and a larger study or meta-analysis would be helpful in quantifying these associations more precisely. The low power of the study also meant that where no association was found, it was not possible to say that no association existed.

The study used questionnaires which may not give as reliable information as that obtained by interview. A study by O'Sullivan and Fitzgerald showed that many more adolescents described themselves as having suicidal thoughts on a questionnaire than when followed up by interview.[8] It is not possible to say whether adolescents are more or less likely to be honest about suicidal thoughts and acts in a questionnaire or an interview.

The study used questionnaires which were not specific for suicidal behaviours. The CBCL and the YSR are general screening instruments to detect young people at risk of mental health disorders. More specific questionnaires, such as The Children's Depression Inventory, might have given more information about mood and suicidality but would not have provided a general measure of psychological functioning, and might have been less acceptable to parents and schools, given their focus on depression.

Females were over-represented in the school sample. The questionnaires were sent to parents of equal numbers of boys and girls, but completed questionnaires were received from significantly more girls and their parents. We can only surmise why this may be. It may reflect a greater reluctance by adolescent boys to participate in a study of this kind, and/or greater reluctance by their parents to encourage them to participate. The preponderance of males in the mental health service attenders sample reflects the fact that two thirds of attenders at virtually all child and adolescent mental health services in westernised cultures are male.

Bearing in mind the above reservations, it is useful to compare our findings with those from other countries. This study suggests that suicidal thoughts are reported by somewhat fewer community-based Irish adolescents than those in the USA (15% v 27-30%).[6,7] Rates of reported acts of self-harm do not differ between adolescents in the two cultures (8% in both Ireland and the USA).[6] The difficulties in making comparisons with other European countries have already been outlined.[10]

The gender differences in this study (more girls than boys reporting thoughts and acts of self-harm in the mental health service attenders, but more boys than girls reporting acts of self-harm in the community school-based sample), are difficult to explain. It appears that thoughts of self-harm are relatively common in boys and girls, but that boys in the community are much more likely than girls to act on those thoughts. This does not explain why more girls than boys who have been identified as having mental health problems report acts of self-harm. Many factors have been put forward to explain these gender differences, mostly involving differences in socialisation of girls and boys, but we are far from having a clear understanding of what lies behind the differences.

Table 4: **Gender differences in adolescents' reports on the Youth Self Report**

	Male N (%)	Female N (%)	Odds Ratio	95% CI
School sample (195)				
59 male, 136 female				
Thoughts	7 (12%)	23 (17%)	0.66	0.22-1.70
Acts	8 (14%)	7 (5%)	2.89	0.86-9.84
Mental health service attenders (66)				
45 male 21 female				
Thoughts	6 (13%)	8 (40%)	0.25	0.60-1.02
Acts	6 (13%)	8 (40%)	0.25	0.60-1.02

Parents of adolescents attending mental health services were highly aware of risks of suicidal behaviour in their adolescents, but this awareness was not present in parents of the community school-based sample. Youth suicide and suicidal behaviour is now the focus of increased publicity and media attention which may raise awareness in increasing numbers of parents. Increasing parental awareness may be of limited value unless it is accompanied by an increase in parents' sense of competence about how to address their concerns. Much research is currently being carried out to find effective interventions to reduce the rate of youth suicide, but caution is needed, as an intervention which is successful in one culture may not be so in another culture.[17]

Youth suicide and attempted suicide are now major public health problems in Ireland. This study shows that thoughts of suicide and acts of self harm are common in Irish adolescents in the community and are particularly common in adolescents attending mental health services. We know little about the levels of distress and impaired functioning associated with these thoughts, or what determines whether suicidal thoughts will be acted upon. Further studies involving interviews with adolescents at risk are indicated to determine the significance of these thoughts and acts, and how adolescents deal with them.

Acknowledgement

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