

Suicidal thoughts and acts in Irish adolescents

Jo Rowley, Kathleen Ganter, Carol Fitzpatrick

Ir J Psych Med 2001; 18(3): 82-86

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

Jo Rowley, MB DPM MRCPsych, Specialist Registrar in Adult Psychiatry, Lagan Valley Hospital, Lisburn, Northern Ireland.
 Kathleen Ganter, MB MSc (Mgmt) MRCPsych, Consultant Child Psychiatrist, Lucena Clinic, 59 Orwell Rd, Dublin 6, Ireland.

*Carol Fitzpatrick, MD FRCPI MRCPsych, Professor of Child Psychiatry, University College Dublin/Mater Misericordiae Hospital, Eccles St, Dublin 7, Ireland.

*Correspondence

SUBMITTED: FEBRUARY 30, 2001. ACCEPTED: JULY 19, 2001.

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ABBREVIATED PRESCRIBING INFORMATION. **Presentation:** 'Cipramil' tablets 10 mg, each containing 10 mg of citalopram as the hydrobromide. 28 (OP) 10 mg tablets. 'Cipramil' tablets 20 mg, each containing 20 mg of citalopram as the hydrobromide. 28 (OP) 20 mg tablets. **Indications:** Treatment of depressive illness in the initial phase and as maintenance against relapse/recurrence. Treatment of panic disorder, with or without agoraphobia. **Dosage: Treating Depression: Adults.** 20 mgs a day. Depending upon individual patient response, this may be increased in 20 mg increments to a maximum of 60 mgs. Tablets should not be chewed, and should be taken as a single oral daily dose, in the morning or evening without regard for food. **Treating Panic Disorder:** 10 mg daily for the first week

increasing to 20 mg daily. Depending upon individual patient response, dosage may be further increased to a maximum of 60 mg daily. Depending upon individual patient response it may be necessary to continue treatment for several months. **Elderly.** 20 mg a day increasing to a maximum of 40 mg depending upon individual patient response. **Children.** Not recommended. Restrict dosage to lower end of range in hepatic impairment. Dosage adjustment not necessary in cases of mild/moderate renal impairment. No information available in severe renal impairment (creatinine clearance < 20 ml/min). **Contraindications:** Combined use of 5-HT agonists. Hypersensitivity to citalopram. **Pregnancy and Lactation:** Safety during human pregnancy and lactation has not been established. Use only if potential

*Cipramil is individual as it is
the most selective SSRI.^{1,2}*

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8

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Legal Category: POM. **Product Authorisation Holder:** Lundbeck (Ireland) Limited, 14 Deansgrange Industrial Estate, Blackrock, Co. Dublin. Further information available on request. **PA Numbers:** 10 mg 776/1/1, 20mg 776/1/2. 'Cipramil' is a trademark. © 1995 Lundbeck (Ireland) Limited. **Date of Preparation:** August 2001. **REFERENCES:** 1. Hyttel J, et al. Rev Contemp Pharmacother 1995; 6: 271-285. 2. Frampton M. J Serotonin Res 1997; 4: 29-45. 3. Cipramil SmPC. 4. Waldinger MD et al. Poster presented at APA Washington, 2000. 5. JW Jefferson et al. Presented at AMACN, Dec 10-14, 2000; San Juan, Puerto Rico. 6. Greenblatt DJ et al. J Clin Psychiatry, 1998; 59 (suppl. 15): 19-27. 7. Edwards JG & Anderson I. Drugs, 1999; 57 (4): 507-533. 8. Data on file.

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			
<i>Thoughts of self-harm</i>			
Absent	165	34.2	(19.3)
Present	30	63.9	(20.2)*
<i>Acts of self-harm</i>			
Absent	181	36.7	(21.1)
Present	14	65.6	(18.7)*
Mental health service attenders			
<i>Thoughts of self-harm</i>			
Absent	53	41.2	(22.0)
Present	13	83.1	(17.3)*
<i>Acts of self-harm</i>			
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.

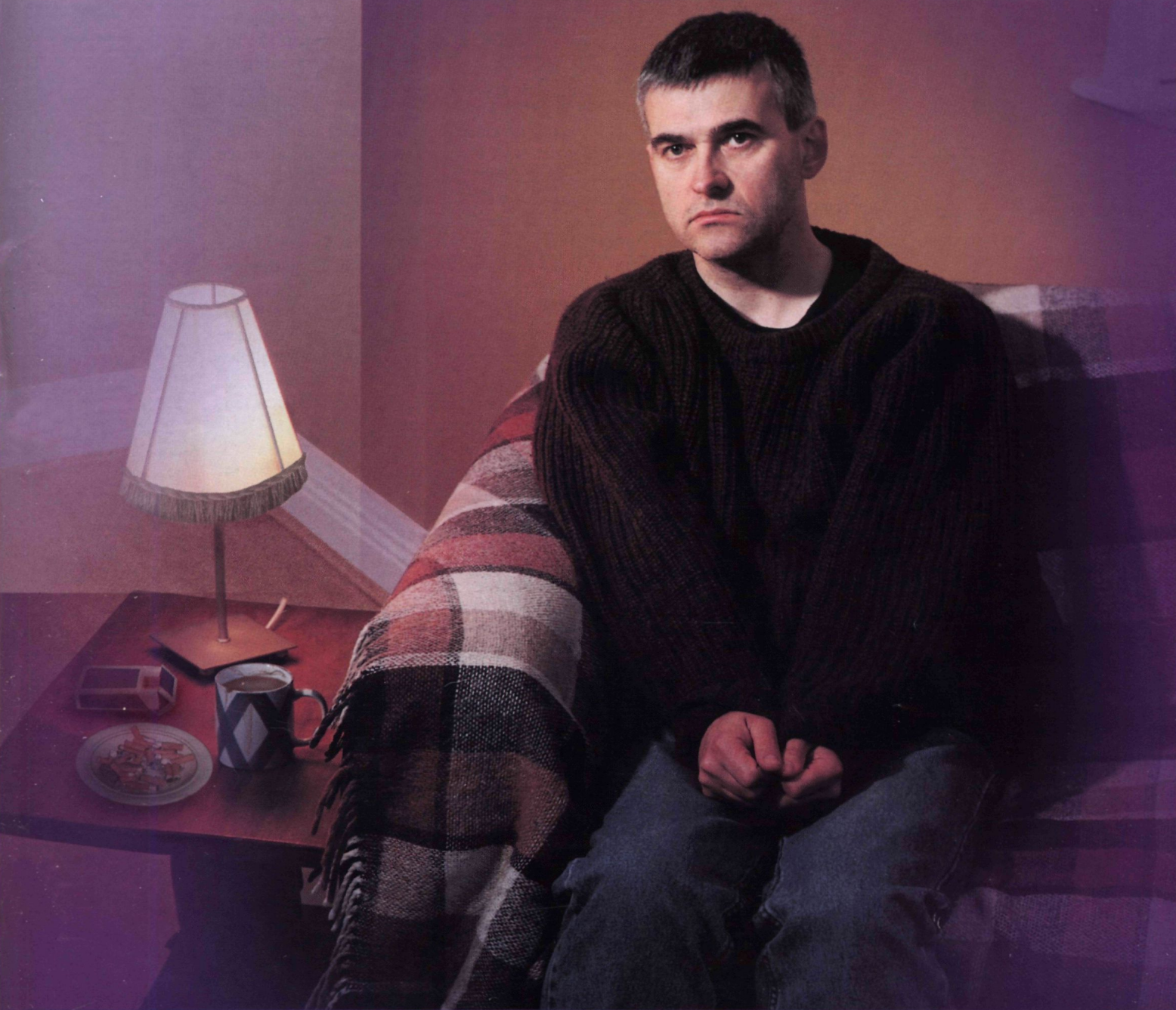
Having received Ethics Committee approval, all parents were sent the CBCL and the YSR with a letter explaining that we wished to gain information about the behaviour and development of Irish young people. The parents were asked to complete the CBCL themselves and to encourage their son/daughter to complete 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...



*John, a 43 year old with schizophrenia,
was on haloperidol and chlorpromazine,
benztropine for EPS,
a benzodiazepine and an antidepressant.
He was stable, but was he well?*

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

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

ZYPREXA (OLANAPINE) REPUBLIC OF IRELAND
VIATED PRESCRIBING INFORMATION: Presently, Zyprexa (olanzapine) is available in the form of coated tablets containing 2.5mg, 5mg, 7.5mg or 10mg olanzapine. The tablets also contain lactose. Velotab 10mg orodispersible tablets. Velotab 10mg orodispersible tablets are freeze dried, rapid-dispersing preparations placed in the mouth or alternatively to be dispersed in or other suitable beverage for administration. Velotab contain aspartame, mannitol and parahydroxybenzoates: Schizophrenia, both as initial therapy and for maintenance of response. **Further information:** In patients with schizophrenia and associated depressive symptoms, mood score improved significantly more than with placebo. Velotab 10mg orodispersible tablets are bioequivalent to olanzapine coated tablets similar rate and extent of absorption. They have the dosage and frequency of administration as olanzapine tablets. Olanzapine orodispersible tablets may be an alternative to olanzapine coated tablets. **Pharmacodynamics:** Olanzapine was associated with significantly greater improvements in both negative and schizophrenic symptoms than placebo or compared studies. **Dosage and Administration:** 10mg/day as a single dose without regard to meals. Dosage may be adjusted within the range of 5-20mg/day increase to a dose greater than the routine therapeutic 10mg/day is recommended only after clinical judgement. **Children:** Not recommended under 18 years. **The elderly:** A lower starting dose (5mg/day) is not indicated but should be considered when clinical warrant. **Renal and/or hepatic impairment:** A lower dose (5mg) should be considered. In moderate insufficiency, the starting dose should be 5mg, increased with caution. When more than one factor is present which might result in slower metabolism (elderly age, non-smoking status), consideration should be given to decreasing the starting dose. Dose should be conservative in such patients. **Contra-indications:** Known hypersensitivity to any ingredient of the product. Known risk of narrow-angle glaucoma. **Warnings:** Special Precautions: Caution in patients with hyperthyroidism or paralytic ileus and related conditions. antipsychotic treatment, improvement in the patient's condition may take several days to some weeks. should be closely monitored during this period. Caution in patients with elevated ALT and/or AST, signs and symptoms of hepatic impairment, pre-existing conditions associated with limited hepatic functional reserve, and in patients being treated with potentially hepatotoxic drugs. other neuroleptic drugs, caution in patients with low white blood cell count and/or neutrophil counts for any cause. low drug-induced bone marrow depression/toxicity, bone marrow depression caused by concomitant illness, radiotherapy or chemotherapy and in patients with existing conditions or with myelodysplastic disease. Thirty-two patients with clozapine-related neutropenia/agranulocytosis histories received olanzapine and decreases in baseline neutrophil counts. Rare cases of NMS have been received in association with olanzapine. If a patient develops signs and symptoms indicative of NMS, or presents with unexplained high fever without clinical manifestations of NMS, all antipsychotic drugs, including olanzapine, must be discontinued. Caution in patients who have a history of seizures or are susceptible to tardive dyskinesia appear, a dose reduction or discontinuation should be considered. Caution taken in combination with other centrally acting drugs, alcohol. Olanzapine may antagonise the effects of direct dopamine agonists. Postural hypotension was frequently observed in the elderly. However, blood pressure should be measured periodically in patients over 65 as with other antipsychotics. As with other antipsychotics caution when prescribed with drugs known to increase the risk of falls, especially in the elderly. In clinical trials, olanzapine was not associated with a persistent increase in blood intervals. Hyperglycaemia or exacerbation of pre-existing diabetes has been reported in very rare cases of Zyprexa treatment. In some cases, a prior increase in weight has been reported, which may be a predisposing factor. Appropriate clinical monitoring is advisable in patients and in patients with risk factors for the development of diabetes mellitus. **Interactions:** Metabolism is induced by concomitant smoking or carbamazepine. **Pregnancy and Lactation:** Olanzapine had no teratogenic effects in animals. Because human experience is limited, olanzapine should be used in pregnancy only if the potential benefit justifies the potential risk to the fetus. Olanzapine was excreted in the milk of treated rats and it is excreted in human milk. Patients should be advised not to breast feed an infant if they are taking olanzapine. **etc.** Because olanzapine may cause somnolence, patients should be cautioned about operating hazardous machinery including motor vehicles. **Undesirable Effects:** The most frequent (>10%) undesirable effects associated with the use of olanzapine in clinical trials were somnolence and weight gain. Occasional undesirable effects included dizziness, increased appetite, peripheral oedema, orthostatic hypotension, and mild, transient anticholinergic effects, including constipation and dry mouth. Transient, asymptomatic elevations of hepatic transaminases, ALT, AST have been occasionally observed. Olanzapine-treated patients had a lower incidence of parkinsonism, akathisia and dystonia in trials compared with titrated doses of haloperidol. Photosensitive reaction, rash or high creatine phosphokinase were rarely reported. Rare reports of hepatitis, priapism, seizures, glycaemia or exacerbation of pre-existing diabetes have been received. Rare cases reported as NMS have been received in association with olanzapine. Plasma levels were sometimes elevated, but associated manifestations were rare. In most patients, levels related to normal ranges without cessation of treatment. Haematological variations, such as leucopenia and thrombocytopenia, have been reported occasionally. **For information see summary of product characteristics.**
Marketing Authorisation Numbers: EU/1/96/001/001, EU/1/96/002/004, EU/1/96/002/006, EU/1/96/002/008, EU/1/96/002/010, EU/1/99/125/001, EU/1/99/125/002, EU/1/99/125/003, EU/1/99/125/004, EU/1/99/125/005, EU/1/99/125/006, EU/1/99/125/007, EU/1/99/125/008, EU/1/99/125/009, EU/1/99/125/010, EU/1/99/125/011, EU/1/99/125/012, EU/1/99/125/013, EU/1/99/125/014, EU/1/99/125/015, EU/1/99/125/016, EU/1/99/125/017, EU/1/99/125/018, EU/1/99/125/019, EU/1/99/125/020, EU/1/99/125/021, EU/1/99/125/022, EU/1/99/125/023, EU/1/99/125/024, EU/1/99/125/025, EU/1/99/125/026, EU/1/99/125/027, EU/1/99/125/028, EU/1/99/125/029, EU/1/99/125/030, EU/1/99/125/031, EU/1/99/125/032, EU/1/99/125/033, EU/1/99/125/034, EU/1/99/125/035, EU/1/99/125/036, EU/1/99/125/037, EU/1/99/125/038, EU/1/99/125/039, EU/1/99/125/040, EU/1/99/125/041, EU/1/99/125/042, EU/1/99/125/043, EU/1/99/125/044, EU/1/99/125/045, EU/1/99/125/046, EU/1/99/125/047, EU/1/99/125/048, EU/1/99/125/049, EU/1/99/125/050, EU/1/99/125/051, 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...to reintegration



Antipsychotic Efficacy for Routine Use

ZYprexa
Olanzapine



Making Community Reintegration the Goal

*On Zyprexa monotherapy for 6 months, John is now well.
His EPS has improved,^{1,2,3} his mood has lifted⁴
and he is seeing his friends regularly.*

**Zyprexa - helping to make reintegration
an achievable goal in schizophrenia**

Lilly

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

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

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.

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

The authors wish to thank the parents, adolescents and schools who participated in the study. We also wish to thank Ciaran Dolphin of The Work Research Centre for statistical guidance.

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