Suicide Risk among School-Age Children: What Education Professionals Need to Know

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ABSTRACT

Suicide is a significant concern in the United States and school-age children make up a subset of those who die by their own hands every year. Although research is broadening in terms of scope and output, more study is warranted particularly as it relates to youth suicide risk. Additionally, with the close relationship that education professionals and school age children share, it is imperative that possible warning signs and interventions are identified. Herein the features of childhood suicide risk factors are outlined with the key considerations, and nature of suicidal behavior. Recognizing the prospective approaches to mitigating suicide risk in school age youth are presented.

Keywords: Childhood, Suicidal ideation, Prevention, Risk, Suicide

Overview

In the United States, suicide ranks as the second leading cause of death in children 10 to 19 years-of-age (Centers for Disease Control and Prevention [CDC], 2018). In the U.S., there were 2,553 suicides among children ages 10-19 between 1999 and 2016, which equates to an age-adjusted mortality rate of 6.1 deaths per 100,000 (Curtin, Heron, Miniño, & Warner, 2018). For comparison purposes, the age-adjusted suicide rate for the U.S. population was 15.6 in 2016 (CDC, 2018). Even more troubling is that while CDC researchers report youth suicide decreased by 15% between 1999 and 2007, the rate increased by 56% between 2007 and 2016 (Curtin et al., 2018). Further, there is a significant difference in suicidal behavior among African American children over Caucasian children, as well as across gender (Centers for Disease Control and Prevention, 2016). The CDC suppresses death counts in particular groups if the count is lower than 10, so limited data is available on children under 10 years of age (CDC, 2018). Having said this, we reviewed one entire state's death records for 2001-2016 and discovered the youngest person having died by suicide in that period was 5-years-old. So, while exceedingly rare, even extremely young children could be at risk for lethal self-harm.

As noted in the *Journal of the American Medical Association* (JAMA), suicide rates for African American youth, ages 5-12, are nearly double that of same aged Caucasian children (see Bridge et al., 2018). However, data shows that suicide among that age and demographic reverses in ages 13-17. For that age group, African American teens' suicide rates fall to nearly 50 percent that of Caucasian teens. Differences in the rate of suicide among non-Hispanic Caucasian females ages 10-14 have more than tripled since 1999 (Centers for Disease Control and Prevention, 2015). For the entire population, males account for nearly 78% of all suicides. Suicidal attempts, however, more often occur in females (Hamilton & Klimes-Dougan, 2015). Males employ more lethal means; therefore, are more likely to have a fatal result (Curtin et al., 2018). Female suicide attempts have the potential of creating serious life-long disability so should in no way be taken less seriously.

While there are many causes for suicidal behavior, some stand out. For children with untreated mental health disorders, there is often fear or shame involved that may negatively impacts a child's ability to ask for help. Additionally, many children do not possess the communication skills that would enable them to seek assistance. Such societal impacts as bullying, social media, family and peer relationship problems, and other challenges may cause children to feel hopeless and depressed. Left untreated, this can lead to self-harm. Therefore, prevention efforts are crucial among this population. Contrary to popular belief, asking a person if they are thinking of hurting or killing themselves will not encourage a person to attempt suicide (World Health Organization, 2014). There must be no hesitancy in asking this life-saving question along with whether the person has a plan, access to means, and a history of attempts.

Suicide among school-age children is a significant concern to many, including education professionals. Young children spend much of their day working with teachers and other education professionals. For this reason, it is critical for such individuals to remain cognizant of behaviors which may indicate a cause for concern. Educators should be aware of possible warning signs of suicide and know how to intervene if such a situation is evident. Key considerations of suicidal ideation among school-age children include:

1. **Relationship Challenges.** A common factor in suicidal ideation among young children is relationship problems with family members and friends. While

communication skills are still developing, many children do not have the requisite skills for discussing problems and concerns which leads to internalizing such issues (Kennedy-Moore, 2016).

2. **Mental Health Disorders.** Depression is a leading cause of suicide among children. Left unrecognized or untreated, children do not get the professional help they need to deal with depression. Drug and/or alcohol abuse may also be evident and can be a contributing factor (American Academy of Child & Adolescent Psychiatry, 2017).

3. **Academic/Attentional Difficulties.** Difficulty concentrating, declining grades, unexplained absence from school, and withdrawal may indicate classroom concerns. Students who have been diagnosed with Attention Deficit Disorder are at greater risk of self-harm. Similarly, students who struggle in school often experience feelings of negative self-worth and despair. This combined with impulsivity can lead to tragic consequences (Whalen, Dixon-Gordon, Belden, Barch, & Luby, 2015).

4. **Sociodemographic Differences.** Nearly twice as many African American children die by suicide as compared to Caucasian children. Continued research is needed to identify why this trend is occurring and what can be done to address it (Bridge et al., 2018; Centers for Disease Control and Prevention).

5. **Gender Differences.** Among the cited population, nearly 78% of children who died by suicide between 1999 and 2015 were boys (Centers for Disease Control and Prevention, 2015; World Health Organization, 2018).

6. **Negative Environments at Home and/or School.** Poverty, maltreatment, numerous transitions, negative peer pressure and loneliness can result in children attempting to take their own lives (King & Merchant, 2008; Tishler et al., 2007).

7. **Family History of Psychopathology.** When there is a family history of mood or personality disorders, substance abuse, violence, or suicide, the risk of a child attempting suicide increases (Conner et al., 2014; Whalen et al., 2015)

8. **Genetic Predisposition.** Genetics accounts for between 30 and 50% of suicide risk and in one study researchers found a two-fold increase for the number of suicides in a family that has a history of suicide. Children of parents who suicide have a six-fold increase in suicide rates (Joiner, Brown, & Wingate, 2005).

9. **Withdrawal.** Withdrawing from social interaction with family or friends, or activities that were once pleasurable is a warning sign screened for in the psychological autopsy (PA) process. The PA is a qualitative study done on an individual's death (American Association of Suicidology, 2013). While conducting a PA, one of the authors noted a 16-year-old male, who had died by suicide, had withdrawn from social media and online games in which interaction with other players was a component.

10. **Non-Suicidal Self-Injury (NSSI).** Those who engage in self-arm are at serious risk and are up to 30 times more likely to die by suicide (Cooper et al., 2005). Those engaging in NSSI are exploiting the cingulate cortex area of the brain (Lieberman & Eisenberger, 2015), which serves to temporarily negate psychological pain by replacing it with physical pain. This psychological pain is otherwise known as a *psychache* (Shneidman, 1993;1996).

Young children tend to exhibit warning signs of suicidal behavior at a lower rate than adolescents and adults (Tishler, Reiss, Rhodes, 2007). For this reason, observation and screening are important when considering children who have previous suicidal behavior and risk factors as noted above. Educators must remain aware of potential areas of concern as well as student behaviors which may point to self-harm and injury among young school-age children. If concerns are noted, school counselors and administrators should be advised, and parents notified. Working together, positive interventions can be implemented with the goal of eliminating the child's potential self-injurious response. In the classroom, behavior management and communication skills must be taught and reinforced. Since interpersonal problems are risk factors in childhood suicide, such problem-solving skills should be taught. Providing youth with skills in positive emotional and relationship techniques can aid in reducing suicidal attempts with this age group. It is important to provide all education professionals with information and resources about youth suicide so that they can be proactive in efforts to support students and families when needed. The National Suicide Prevention Lifeline number should be available for students, faculty, and staff. That number is 1-800-273-TALK (8255). Support services and referrals can mean hope and positive outcomes for these children.

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