Recognizing Suicidal Risk in Very Young Children

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ABSTRACT

Suicidal thought and behavior (STB) in preschool and kindergarten-age children is an alarming event. Until recently, these young children's experiences have been under recognized, in part due to an under appreciation for their awareness of the finality of death. Although rare, serious suicide attempts and death by suicide among preschool and kindergarten-age children are well documented. There is limited research on the risk factors that contribute to STB in very young children. We present de-identified case descriptions of very young children seen for psychiatric treatment at a day hospital program who presented with self-injurious behavior and suicidal ideation (SI). The patients described have common risk factors, including exposure to trauma, family conflict and family history of suicidal behavior. It is critical that children presenting with STB be assessed and offered services to mitigate these risks.

KEYWORDS: suicide, suicidal ideation, suicidal attempt, ,early childhood school-age children

INTRODUCTION

Over the past few decades, there is growing recognition that preadolescent children experience suicidal thoughts, engage in suicidal behavior, and die by suicide at alarming rates. In 2018, suicide was the fifth leading cause of death among children aged 5–12, resulting in 185 deaths.[1] Although the overall rate of suicide in school-age children over a 20-year period from 1993–2012 was stable, the rate increased significantly among Black children.[2,3] In 1993, the suicide rate was comparable between White and Black children, but by 2012 the suicide rate among Black children was 2.6 times as high as the rate among White children. Moreover, the age-adjusted suicide rate for adolescents and young adults has increased substantially over the past two decades.[4] School-age children are also presenting more often to emergency departments (ED) with suicidal ideation and suicidal attempts. For example, in a large recent study of inpatient admissions across 14 states, 12% of children under age 12 reported a past suicide attempt.[5] Moreover, 43% of ED visits for suicidal ideation and attempts involved children under the age of 12.[6] There is also emerging recognition that very young children may experience suicidal thoughts and engage in suicidal behavior. One recent study, recruited through pediatric practices, reported that 11% of study participants between ages 3–7 years expressed suicidal ideation to their parents.[7]

Despite the emerging recognition that some school-age children, and even preschool-age children, may experience STB, including attempts, the clinical literature on risk factors for STB in school-age and younger children is limited. Depression, anxiety, disruptive behavior disorders including impulsivity, and exposure to trauma have all been associated with STB in adolescents.[8] Evidence is emerging that this wide range of psychiatric disorders as well as family conflict and low parental monitoring is also associated with STB in preschool and school-age children.[9,10] Moreover, early STB predicts psychiatric impairment including risk for psychiatric day hospital readmission[11] and school-age SI.[7]

Early identification of children at risk for suicide is a critically important step. For the youngest children, who are unable to report on their level of distress and psychiatric symptoms, clinicians must rely on parental report. However, caregivers may not recognize the distress as reflecting suicidal ideation due to beliefs that young children have limited awareness of the finality and irreversibility of death. And yet, studies have consistently found that children as young as 4-years-old grasp the biological finality of death, and that most children have a mature understanding of death by ages 6–7.[12,13,14]

METHODS

To illustrate how these young children exhibit suicidal thoughts and behaviors, the current paper provides several de-identified composite case descriptions (with fictional first names) of preschool and young school-aged children who presented to an early childhood psychiatric day hospital with concerns about behavioral and emotional dysregulation, self-injurious behavior, and STB. All children received the standard clinical assessment protocol and the case presentations reflect information gathered as part of the standard clinical protocol.

CASE DESCRIPTIONS

Child #1: Lee-Anne is a 4-year-old girl admitted for psychiatric day hospitalization to address escalating self-injurious and aggressive behavior, depressed mood with irritability, death and negative self-statements including suicidal ideation. Lee-Anne lived with her mother, step-father, and two older siblings. Parents noted that Lee-Anne started to exhibit seizures in early infancy. Her parents separated following several episodes of domestic violence in later infancy. Lee-Anne reportedly exhibited frequent temper loss dating back to just after her second birthday. Parents described her as not only "headstrong," easily frustrated, and often non-compliant, but also "loving" and "a good girl who worries too much about her family." Mother reported extended family health issues with several hospitalizations over the past year, which has resulted in significant family stress.

Prior to admission, parents noticed that Lee-Anne scratched herself on multiple occasions and tried to hide them afterward. She also banged her head more frequently during temper-loss episodes, while saying that she wanted to hurt herself. Parents started to routinely check for scratches every day, which Lee-Anne frequently resisted. Lee-Anne also started talking more about death, expressed more worries about her parents' health, and resisted separations more in the months prior to her day hospitalization.

Upon day hospital admission, Lee-Anne started to say that she wanted to die, both at home and in the program. Lee-Anne protested separations upon morning arrival, appeared more often sad and tearful, and reacted with aggression to staff and family members. In response to supportive interventions by staff, Lee-Anne exhibited irritability, self-injurious behavior, and intensifying aggression which required physical interventions for safety. During these episodes of self-directed aggressions, which involved pinching, scratching, and banging her head forcefully against the wall, Lee-Anne also stated that "I want to die," "I want to kill myself," and "God should kill me in an accident." Her parents expressed the belief that these suicidal statements reflected Lee-Anne's intention to die. These episodes of behavioral dysregulation and SI appeared to be associated with separation distress, and worries about the health and well-being of immediate family members.

Child #2: Joey, a 5-year, 4-month-old boy, was admitted for psychiatric day hospitalization to address escalating aggression towards family members, self-injurious behavior, anxiety, and constipation with overflow and fecal smearing. Joey lived with his adoptive parents and sibling. He did not see his two older biological siblings who were adopted by another family. He also lost contact with his younger biological sibling who was reunified with the biological parents. Joey's maltreatment or neglect history prior to foster care was unknown. He was placed in two foster homes prior to placement with his then pre-adoptive parents. Within the first year of placement, his biological parents' rights were terminated and his adoption was finalized. Joey's adoptive parents cited the loss of contact with his younger sister as particularly distressing, and reported that he often mentioned missing his sister.

At day hospital admission, Joey's parents reported multiple episodes of losing his temper per week, which included throwing himself to the floor with force, face and arm scratching, headbanging on floor, walls, and door edges, throwing objects at family members, and prolonged screaming and crying. These episodes lasted 30–45 minutes and occurred several times per week, up to several times per day. During one temper-loss episode before admission, Joey's parents reported that he stated that he wanted to be dead, but they were unable to recall additional details about the statement.

At the day hospital program, Joey exhibited several high-intensity temper-loss episodes, with self-directed aggression that included scratching and headbanging with force, and screaming. During episodes of dysregulation, which lasted between 15–20 minutes, Joey received 1:1 care but did not require safety interventions. Joey responded impulsively to comments from staff to help him orient and prepare for upcoming transitions among activities. Following these prompts, Joey often displayed rapid-onset hyperactivity and increased frustration. He also avoided eye contact, screamed, but no self-harming statements were noted.

His mother reported that she tried to manage self-directed aggression at home by offering choices. She noted that when she prompted him to consider a different choice following continued dysregulation, he often stated "but it's okay to hurt myself." Mother also noted that Joey occasionally expressed concerns that others might come to some harm, including dying, after prolonged separations. He also wondered if his biological father had died.

As part of his day hospital program evaluation, Joey was administered a brief, structured interview measuring his understanding of key biological concepts of death.[15] Joey's answers indicated a good grasp of the concepts of finality and irreversibility, emerging understanding of non-functionality, and limited awareness of internal causes of death.

Child #3: Frank is a 6-year, 11-month-old boy who was admitted for day hospitalization for self-injurious behavior and suicidal statements, including "I want to kill myself" and attempted self-choking. Frank lived with his mother and younger sister during the week and visited with his father and stepmother on most weekends and one afternoon every other week. Frank had expressed the wish to die and kill himself on multiple occasions at home and school. He had also displayed oppositional and defiant behavior, and often refused to comply with directives from adult caregivers. Frank attended a regular first-grade classroom, and the school team was in the process of evaluating him for special education eligibility.

Frank's history was noteworthy for prenatal complications, developmental delays in motor coordination and planning, attention deficit hyperactivity disorder (ADHD), anxiety, exposure to significant family conflict, and parental divorce. Frank had a long history of inserting objects in his mouth. Extended family history was significant for suicide. In addition, Frank's mother reported that he had a long history of expressing grief for a family member who died when he was an infant.

Frank expressed numerous suicidal statements during the course of his day hospitalization. Several of these statements were violent, including wanting to cut off his head with a knife and putting a gun in his mouth to reunify with a lost relative. He also disclosed a past attempted suicide that was not witnessed. Specifically, he reported during an interview assessing his understanding of death that "I attempted to cut myself with a knife to sacrifice yourself – if someone else dies and you feel sad." Frank was also able to explain the difference between a general death and "killing oneself." On several occasions he attempted to sit on a window sill while stating, "I will fall off and break my neck." In addition to multiple SI and non-suicidal statements, Frank exhibited prominent aggressive behavior towards staff when distressed or appearing agitated.

Child #4: Sandy is a 5-year, 6-month-old girl admitted for day hospitalization to address increasing aggression, self-injurious behavior, sexualized behavior, impulsivity, negative self-statements, and property damage. Additional concerns included gagging on non-preferred foods, and sleep difficulties, including delays in sleep onset and night waking. Sandy lived with her mother and father. History was noteworthy for exposure to domestic violence and physical abuse. First-degree family history was significant for SI and past suicide attempts (SA).

Upon program admission, Sandy displayed intermittent temper loss with moderate intensity to staff. She also displayed brief headbanging and wall kicking when frustrated with staff prompts and redirections. Sandy expressed the following suicidal ideation at home and in the program: "I wish I wasn't here," and "I want to go to sleep but I don't want to wake up."

Sandy's mother did not believe that Sandy intended to harm or kill herself when she expressed SI and engaged in self-injurious behavior. Mother stated, "She is too young; she doesn't know what she is saying." Mother also reported that "she acts this way for attention." Sandy was administered an interview measuring her understanding of key biological concepts of death[15] as part of her program evaluation. Sandy's answers indicated an emerging understanding of the concepts of finality, irreversibility, and non-functionality, but limited awareness of internal causes of death.

TREATMENT

The focus of treatment for very young children presenting with STB is initially focused on crisis stabilization and helping parents to identify and manage safety concerns. Clinical support following initial stabilization includes facilitating problem identification, communication of distress, promoting the child's experience of feeling understood, and helping the child and parents share activities that increase positive and decrease negative experiences or interactions. For children admitted to psychiatric day hospitalization, intensive parent-child guidance is a core element of the treatment plan. Treatment is optimally provided by a multi-disciplinary team including pediatrics, psychiatry, psychology, occupational therapy, speech therapy, nursing, and behavioral health staff. Upon discharge from the higher level of care, families can expect to continue in outpatient treatment, which may include a home-based component with the support of psychiatry, pediatrics and psychological services, and collaboration with their school teams.

DISCUSSION

These cases illustrate the recently established finding that young children can exhibit suicidal thinking and behavior[16] by introducing children ages 4-, 5-, and 6-years-old who were observed by clinicians and reported by parents to make suicidal and death-related statements and physical aggression towards themselves and others. This is consistent with research that shows that preschool-onset depression occurs in children as young as age 3,[17] with multiple documented cases of preschool children having serious suicide attempts and death by suicide.[18] It is important to keep in mind that depressed children present differently than adults; the more common presentation seen in adults of withdrawal and neuro-vegetative symptoms is much less likely in early developmental levels. Although most young children with SI present with heightened irritability or distress, and impulsive and disruptive behavior, we do recommend routine suicide screening for young child with significant withdrawal, depression and anxiety. Children with internalizing presentations may be more difficult to identify for suicide screening and support because they are quiet and not disrupting others. It is critical that young children exhibiting symptoms of depression receive a full behavioral-health assessment and be offered interventions to prevent negative outcomes in the context of later risk. Researchers are continuing to investigate effective interventions for this population,[19] with the hope that provision of services to this population and their families at an early stage will prevent further development of depression and its sequelae in later years. Very young children's self-injurious behavior and suicidal statements represent real distress and psychiatric impairment, which is deserving of further assessment and referral for treatment.

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Disclosures

The authors do not have individual conflicts of interest to disclose.

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