

The relationship between child maltreatment, sexual abuse and subsequent suicide attempts

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Contents

Introduction	3
Key findings	4
1 Incidence rates	5
2 Behaviours prior to suicide in a developmental context	7
3 Sexual victimization	10
4 School bullying and suicide	17
5 Vulnerable populations & incidence rates	20
6 Developmental considerations	21
7 The role of the media and the Internet	23
8 Recommendations for future research and practice	25
Conclusions	28
Bibliography	29

List of tables

Table 1 A survey conducted with parents of and children aged 11-15	7
Table 2 Demographic details of parents and children who reported self-harm/ suicidal thoughts/attempts	23

List of figures

Figure 1 Average number of suicides per year 1999-2006	5
Figure 2 Model of suicide risk factors	16
Figure 3 Model of suicide prevention	27

Introduction

The purpose of this briefing is to evaluate the relationship between child abuse (particularly sexual) and other risk factors present during childhood, and subsequent suicide attempts. Incidence rates are also discussed.

The two main methods of studying child suicide are through studies of children and young people who have survived suicide attempts, and of the lives of those who did not. However, there is relatively little concrete evidence on childhood suicide and therefore much of the evidence presented in this report relates to suicide in later life.

Many professionals would argue that child suicide is not possible, because a child does not have a concept of death and dying. Baechler (1979) argued that a child must be of an age “...when the subject is capable of understanding the meaning of the act, exactly in the same way as one must attain a certain age to be able to learn to read and write.” This suggests an age of around six or seven years. However, Rosenthal (1979) identified the youngest reported suicide in America in 1979, of a boy aged two-and-a-half.

Key findings

- Mortality figures in the UK indicate that suicide attempts only tend to be recorded for children aged 10 or over, although it is known that young children have shown evidence of suicide ideation.
- Suicide ideation is common among young people in the UK (Meltzer et al 2001; Meltzer, 2002).
- Although there are many different factors related to suicide, research has indicated that the frequency of adult suicide attempts is greater among men and women who have experienced child sexual abuse than those who have not experienced such abuse (Hawton et al, 2002).
- Men are more likely to commit suicide than women, but women are more likely to engage in non-fatal suicidal behaviours (ONS, 1999-2000).
- Sexual abuse in childhood that involved touching results in greater suicide ideation in early adulthood than other non-contact forms of sexual abuse. (This relates to research involving adults, which shows the long term effects of early childhood sexual abuse.)
- Research evidence from Kim et al, (2005) suggests that there is a link between bullying and suicide ideation among victims and perpetrators.
- None of the studies examined in this report explain how sexual abuse leads to greater risk of suicide attempts or behaviour, or why there is a greater frequency of suicide attempts in girls rather than boys following sexual abuse.
- Suicide pacts are extremely rare in the UK, accounting for 0.6 per cent of all suicides (Brown & Barraclough, 1997). However, in some communities with a higher frequency of suicides it is more likely that suicidal behaviours have unfortunately become “normalised” and considered acceptable.

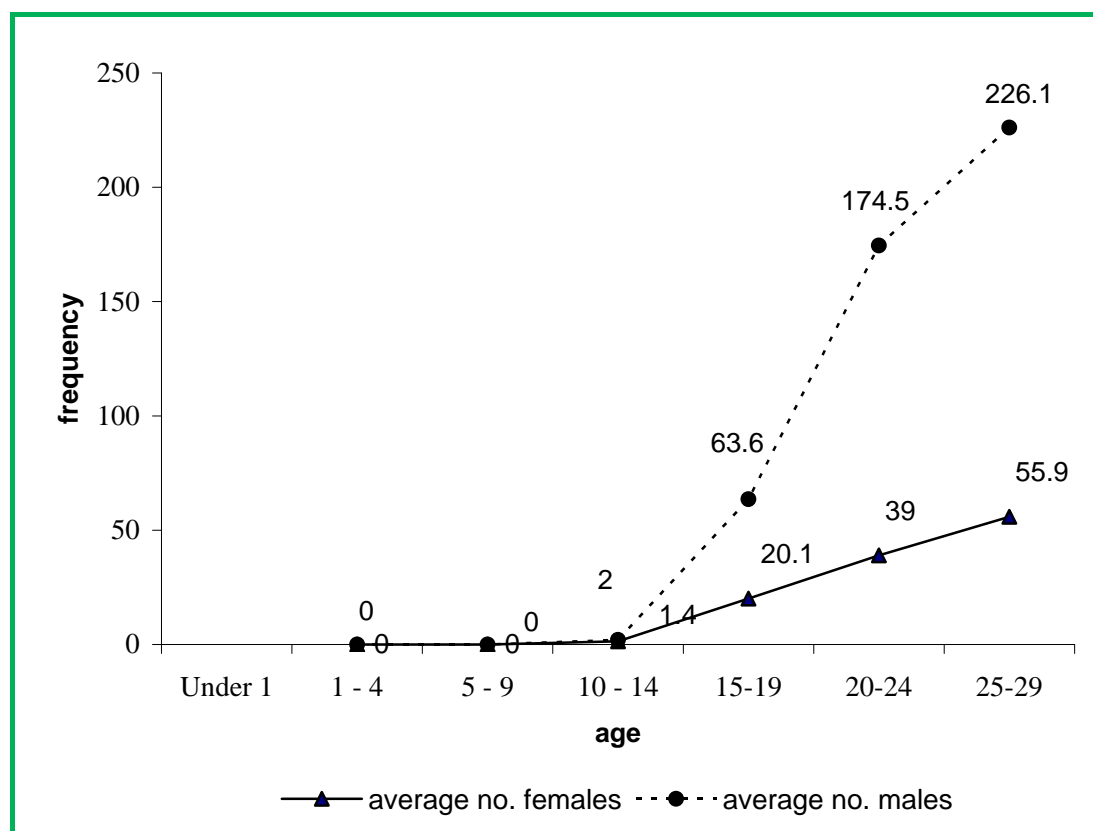
1 Incidence rates

Incidence rates can be examined in terms of

- the number of actual suicides per year
- the number of attempted suicides
- how many children and young people have considered suicide at some time.

The chart below shows the average annual number of suicides in the UK for the period 1999 to 2006, by age group.

Figure 1 Average number of suicides per year 1999-2006



Sources: Office for National Statistics for England & Wales, London: Mortality statistics, DH2 series, Review of the Registrar General on deaths by cause, age and sex, in England and Wales (1999-2006)

These suicide statistics would seem to indicate that suicide is relatively rare in younger age groups but we need to question how reliable this data is, bearing in mind the potential difficulties involved in establishing whether a death is accidental or the result of a suicide attempt. If certain precipitating behaviours are not known at the time of a child's death, a

coroner could conclude that death due to overdosing, falling from a height; running in front of a car or even setting fire to oneself may have been a tragic accident. Even if such behaviours were evident before death, medical examiners may be reluctant to label it as a suicide for fear of stigmatising or traumatising the parents.

Survey data from Australia suggest that suicide ideation is widespread among young people there: Pearce and Martin (1994) surveyed 14- to 17-year-olds attending state school in a middle-class area of Adelaide. Almost half, 49 per cent, had considered killing themselves at some point; 14 per cent had made specific plans; 13 per cent had made threats to commit suicide and 9 per cent reported they had tried to kill themselves. While survey data can reveal “false positives”, these figures illustrate a high incidence of suicide ideation, though in many cases it did not lead to an actual attempt.

In the US, Rubenstein et al (1989) found that in a sample of 300 14 to 18-year-old school pupils, 20 per cent (43 male, 17 female) admitted to being suicidal, that is, they admitted to trying to hurt or kill themselves within the last twelve months. This proportion was considerably lower in a study of 1,051 eight-year-olds in Seattle, which found that 9.9 per cent reported suicidal ideation (Thompson et al, 2005).

The figures for children and young people in the UK who self-harm, with or without the intent to attempt suicide, are lower than Australia and America. Between 7 and 14 per cent of all adolescents will self-harm at some point in their lives. However, between 20 to 45 per cent of older adolescents will have suicidal thoughts (Hawton & James, 2005). Around 140,000 cases are presented to A&E each year (Shiner, 2008). Finally, 9 per cent of all serious case reviews in England from the period 2003-2005, involved the suicide of a child or young person (Brandon et al, 2008).

Meltzer et al (2002) found that 33 per cent of young people aged between 16 and 24 admitted to self-harm; 17 per cent of this age group had also considered suicide and 17 per cent had attempted suicide. In younger age groups, the frequency of self-harm, suicide ideation and suicide attempts was similarly high. In an earlier study by Meltzer et al (2001), parents of children aged between 11 and 15 were surveyed along with the children on the issue of self-harm, suicide ideation and suicide attempts. Table 1, below, gives the frequencies for self-harm and suicide according to the responses by parents and children. The research showed that 2.1 per cent of 11- to 15-year-olds had tried to harm themselves or attempt suicide. As expected, a higher frequency was observed for girls (2.5 per cent) than boys (1.8 per cent). It

was also noted that a higher frequency of self-harm and attempted suicide was observed by parents for those aged 13 to 15 than those aged 11 to 12. The highest rate was for girls aged 13 to 15 (3.1 per cent). This study also asked children whether they had ever tried to harm or kill themselves. Significantly, a higher rate was observed across all categories than that reported by parents. This may be because parents are unaware of the true nature of the problem or that they were uncomfortable about identifying such behaviour in their children.

Table 1 A survey conducted with parents of and children aged 11-15

	11-12 year olds			13-15 year olds			All children		
	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Parents report	%	%	%	%	%	%	%	%	%
Child has tried to harm, hurt or kill himself/herself	1.6	1.5	1.6	1.9	3.1	2.5	1.8	2.5	2.1
Child has not tried to harm, hurt or kill himself/herself	98.4	98.5	98.4	98.1	96.9	97.5	98.2	97.5	97.9
Base	929	922	1,851	1,344	1,388	2,681	2,273	2,260	4,532
Child's report	%	%	%	%	%	%	%	%	%
Child has tried to harm, hurt or kill himself/herself	4.6	4.4	4.6	5.3	7.9	6.6	5.0	6.5	5.8
Child has not tried to harm, hurt or kill himself/herself	95.4	95.6	95.4	94.7	92.1	93.4	95.0	93.5	94.2
Base	884	879	1,764	1,209	1,179	2,559	2,161	1,161	4,323
All reports	%	%	%	%	%	%	%	%	%
Child has tried to harm, hurt or kill himself/herself	5.7	5.2	5.5	6.1	9.0	7.5	5.9	7.5	6.7
Child has not tried to harm, hurt or kill himself/herself	94.3	94.8	94.5	93.9	91.0	92.5	94.1	92.5	93.3
Base	948	936	1,884	1,362	1,361	2,722	2,310	2,297	4,606

Source: (Meltzer et al, 2001)

2 Behaviours prior to suicide in a developmental context

Suicide is often preceded by a series of self destructive behaviours, and some research has considered whether or not repeated self-harming is an indicator of subsequent suicide. Rosenthal and Rosenthal (1983) described a number of studies of preschool children who had displayed certain behaviours prior to suicide: suicide ideation, self-destructive behaviour, and previous suicide attempts.

Suicide ideation refers to the cognitions surrounding the act of suicide. These include the reasons for wanting to die; the planning of the event; and the effect of the suicide on others who are significant in the person's life.

Self-destructive behaviour refers to acts of harm against oneself or others. These behaviours are often displayed without any evidence of remorse or pain, and may be indicators of a rehearsal for the final act.

Suicide attempt refers to significant, life-threatening harm inflicted on oneself. The individual survives the suicide, usually through being discovered by another and receiving rapid medical attention.

Rosenthal and Rosenthal (1983) described seven cases of children ranging from two-and-a-half to four years of age who had attempted suicide, all of whom had displayed each of the behaviours described above. The suicide attempts ranged from overdosing on the mother's anti-depressants, overdosing twice on aspirin, head-banging resulting in bleeding and emergency treatment (all of these related to children aged two-and-a-half); running in front of cars (age 2 years 10 months); throwing themselves from heights (age three and three-and-a-half) and setting fire to oneself (age four). It could be argued that children show such behaviours as a cry for help, wishing to inflict harm on themselves rather than actually wanting to die. In response, Rosenthal argued that the presence of suicide ideation is the key. The preschoolers featured in this study described the reasons why they had wanted to die, which ranged from perceiving themselves to be bad children; wanting to avoid living with a particular person; or wanting to be reunited with a caregiver who had previously died. Moreover, these children showed no fear of their attempts, subsequent attempts or death itself.

According to Sprague (1997) the most accurate predictors of suicide are previous attempts and mental health problems. Shaffer (1994) agrees that retrospective studies of suicide among young males show that a previous suicide attempt is the strongest predictor of suicide, asserting also that for young females there is typically a prior episode of depression. In up to 90 per cent of cases there is a strong association between suicide and some form of psychotic disturbance. The practice implications of these findings are that mental health problems in adolescence need to be taken seriously, and that those who have tried to commit suicide need appropriate monitoring and follow-up.

Sprague (1997) also suggests that a young person's suicide is often described as a consequence of their experiences, which tends to de-stigmatise it and lead to it being viewed as a reasonable option. Young people are sometimes not very good at identifying anxiety and depression as symptoms that can be alleviated through outside help (Shaffer, 1994). It follows that they need to learn to identify identifying anxiety and depression, and to understand that there are alternatives. This should prompt them to seek help rather than resort to more drastic and fatal measures.

Some retrospective studies of suicide attempts also support the view that young people often regard suicide as a means of relief from a situation: Kienhorst et al (1995) found that 80 per cent of young people who had attempted suicide agreed that the situation was "so unbearable that I had to do something and I didn't know what else to do;" 75 per cent agreed they had "wanted to stop feeling pain;" while only 18 per cent claimed their attempted suicide was "to make people sorry for the way they have treated me," i.e. for revenge. Despite these cognitions, around one-third of respondents had engaged in normal daily activities in the hours preceding the attempt, though 28 per cent had thought about going away, wanting rest, stopping consciousness or wanting to die. The most predominant emotion recalled in the hours leading up to the event was depression (44 per cent); anger/rage (20 per cent), while only 15 per cent had positive emotions prior to the attempt. Given the above discussion about behaviours and emotions leading up to suicide attempts, Sprague (1997) suggests that suicidal thoughts may be phasic in nature and can even be short-lived. In other words, some may have suicidal thoughts but do not carry them out and the negative feelings pass.

It is worth considering if repeated self-harming is an antecedent to suicide. The research offers mixed findings on this issue and clearly more investigation is needed to understand the timeline between self-harming and subsequent suicide. Hawton and Harris (2008) studied the outcome for children and adolescents presented to general hospitals in Oxfordshire due to self-harm over a 26 year period (1978-2003). They examined how many went on to commit suicide. The sample consisted predominantly of children aged 12 to 14, mostly female, who had taken overdoses (95.8 per cent). Of this sample, 26.8 per cent had a previous history of self-harm. This suggests that the long-term risk of suicide following a history of self-harming is relatively low, and that the self-harming itself provided the necessary outcome for these children, rather than suicide.

However, this contrasts with research by Zahl and Hawton (2004), who investigated the long-term risk of suicide when there is a history of self-harm in young women aged between 10

and 24: a wider age range than in the previous study by Hawton and Harris (2008), which may account for the difference in results. They followed up patients presented to Oxford general hospital between 1978 and 1997. Of these patients, 39 per cent reported repeated self-harm and they were at greater risk of suicide attempts than single-episode self-harming patients. Repeated self-harming was more common in women than men, and especially in younger women (aged 10 to 24), who showed the greatest risk for subsequent suicide. Also, the time between self-harm and suicide was much shorter in the repeated self-harming group than the single-episode self-harm group. This relates to risk but also to the more general suicidal behaviours of those who self-harm repeatedly.

3 Sexual victimization

The link between early sexual abuse and later suicide ideation or suicide attempts is quite a controversial area. The research listed and discussed below has examined this relationship in adult as well as adolescent samples.

There is a wealth of research into the relationship between sexual abuse in childhood and/or later life and subsequent suicidal ideation/attempts. In general, studies are retrospective, analysing the circumstances of survivors of suicidal attempts. Some have studied adult samples (Romans et al., 1995; Merrill, 2001; Molnar, et al 2001; Meltzer et al, 2002), but many have analysed adolescent samples (Garnefski et al, 1992; Nelson et al, 1994; Bensley, Van Eenwyk, Spieker & Schoder, 1999; Borowsky, Ireland & Resnick, 2001; Wonderlich, et al., 2001; Silverman, et al 2001; Ackard & Neumark-Sztainer, 2002; Shiner 2008. Others have used psychiatric/clinical samples (Coll et al, 1998; Law et al, 1998; Rubenstein et al, 1998; Milnes et al, 2002; Ulman & Brecklin, 2002); college student samples (Boudewyn & Liam, 1995; Peters & Range, 1995; Skepakoff, 1998; Thakkar et al, 2000; Nilsen & Conner, 2002); or deviant samples, i.e. runaways and the homeless (Proctor & Groze, 1994; Shaffer & Caton, 1983; Molnar et al, 1998).

Ulman (2004) examined the relationship between sexual victimization and suicide ideation, suicide planning and suicide attempts, and argued that sexual abuse of girls/women increases the likelihood of suicide attempts. These attempts appear to be precipitated by psychiatric (e.g. depression, PTSD) and psychosocial factors (e.g. substance misuse, risk-taking behaviour). Similarly, Merrill (2001) sampled US Navy female recruits and found that those

who had experienced child abuse were more likely to report suicide behaviours/ideation than those who had not.

Women are more likely to engage in non-fatal suicide behaviours than men (Brockington, 2001; Canetto & Lester, 1995). This higher frequency of suicide attempts in adult life is comparable to patterns in adolescence: one study found that one in 10 girls had attempted suicide compared to one in 25 boys (Lewinsohn, Rohde & Seeley, 1996). One reason for this is that girls are more likely to be abused than boys.

Molnar, Berkman & Buka (2001) examined suicidal behaviour and sexual abuse in the National Comorbidity Survey, and the frequency of sexual abuse within this sample. They found that the frequency of suicide attempts was greater for men and women who had experienced child sexual abuse. First attempts were most likely to occur in early adolescence and were associated with sexual abuse history and a lifetime disorder. This was in contrast to first attempts that occurred in later life. Females were more likely than males to report their suicidal behaviour. The authors concluded that there is a strong association between child sexual abuse and suicidal behaviour, mediated by certain psychological problems.

Ulman & Brecklin (2002) investigated the national comorbidity survey, looking at females only. They investigated the relationship between a number of different variables: the nature of sexual victimization; stressful/traumatic life events; post traumatic stress disorder (PTSD), depression; and whether sexual victimization precedes or follows the onset of suicidal behaviour, including attempts and suicide ideation. The researchers found that women with a history of childhood and adulthood victimization were associated with a lifetime of suicide attempts. PTSD, depression and alcohol-dependence were associated with suicide ideation. Traumatic events and depression were associated with suicide attempts.

Romans et al (1995) screened a random sample of 3,000 women. From this sample 252 child abuse victims and 225 non-victims were selected. Those who had experienced child abuse reported greater self-harm and this applied particularly to those who had endured more intrusive and prolonged abuse. Victims whose abuse had involved force; living away from parents; cohabiting before the age of 19; and sexual assault before age 15 were more likely to self-harm. The frequency of past suicidal behaviour was comparatively higher among victims of child sexual abuse where sexual intercourse was involved. This finding was consistent even when the authors took mental health problems into account in their analyses (Mullen et al, 1993).

The contribution of child sexual abuse to suicidal behaviour is further endorsed by a study by Merrill (2001) who found that in a sample of female US Navy recruits, a history of child sexual abuse was related to suicidal ideation and suicidal behaviour. Women who had higher trauma symptomatology had experienced physical abuse and/or sexual abuse as children.

In the UK, the relationship between abuse and subsequent suicide ideation and suicidal attempts was examined by Meltzer et al (2002). The research indicated that 59 per cent of women who reported sexual abuse also reported suicidal ideation, and this compares to 40 per cent of men. Suicide attempts were also more common among those who had experienced sexual abuse, violence in the home or running away from home. The authors suggest that self-harm, suicidal thoughts and suicidal attempts have different triggers for the different sexes. For men, sexual abuse was more likely to predict self-harm than suicide, whereas for women it was more likely to predict suicidal behaviours; other factors such as being expelled from school were the more likely triggers for self-harming.

Studies of adult samples have shown a link between sexual abuse and subsequent suicidal behaviours, but they do not tell us how sexual abuse leads to suicidal ideation and behaviours. Ulman & Brecklin (2002) suggest that multiple sexual abuse both in childhood and adulthood is a stronger predictor of suicidal behaviour than a single incidence of sexual abuse; Molnar suggests that mental health problems may have a mediating effect. Such research seems to suggest that certain factors that can lead to suicide, such as repeated sexual abuse, may have a cumulative effect on a woman's psyche, which can compound into thoughts of suicide.

Studies using adolescent samples have similarly demonstrated the relationship between sexual abuse and suicidal ideation/attempts, although it is one of several factors which can prompt a suicide attempt: Borowsky, Ireland and Resnick (2001) found that certain circumstances increase the risk of suicide ideation. For girls the risk factors for suicide attempts were previous attempts; being a victim or perpetrator of violence (sexual assault was included in this variable); substance/alcohol use; and school problems. However, in Nelson, Higginson and Grant-Worley's (1994) study, those students who had experienced sexual abuse within the past year reported a higher frequency of suicide ideation than students who had not.

The reasons why females attempt suicide more often than males is addressed in a study by Nelson et al (2001). Their sample of adolescents aged 14 to 17 revealed that females had had far more suicidal thoughts and suicide attempts than males, which coincided with a greater

incidence of sexual abuse. The authors explored the view that the higher anxiety levels among females in their study may have been due to greater anxiety about the sexual abuse. Another American study of 4,163 teenage girls (9th and 12th grade students, aged 14 to 18) examined the relationship between physical and sexual dating violence and subsequent mental and physical health effects. It was found that physical and sexual dating violence was associated with substance abuse, eating disorders, sexual risk behaviours, unplanned pregnancies and suicide attempts (Silverman, et al 2001).

The antecedents to these suicide attempts may be comparable with the frequencies of sexual abuse and psychiatric disorders within this vulnerable group. Many women who have been the victim of a sexual assault will experience either psychological or health problems, or both, as a result (Golding, 1999; Resick, 1993). Studies have repeatedly shown how a history of sexual abuse predisposes women to commit suicide. (Nelson et al, 1994; Romans et al, 1995; Silverman et al 2001; Borowsky et al 2001; Wunderlich, et al, 2001; Ulman & Brecklin, 2002).

The research in the UK also shows a link between sexual abuse and self-harm (Hawton et al, 2002) and sexual abuse and suicide attempts (Milnes et al, 2002). Research needs to examine the nature of the sexual abuse, be it one event or repeated, and the age at which abuse took place, in order to explain how sexual abuse in childhood leads to suicide attempts in later life: Is it the nature of the sexual abuse or is it the age at which it takes place that is the most damaging?

Research tends to focus upon the stressful life events (Meltzer et al, 2001) or interpersonal problems (Hawton & Harris, 2008) and unfortunately does not ask about the incidence of abuse experienced in childhood or adolescence.

One problem in the studies discussed so far is that the questions asked to assess suicidal behaviour and various forms of abuse/violence are condensed into a single screening item (Nelson, et al, 1994; Wonderlich, et al, 2001; Silverman, et al, 2001). The studies discussed below use multiple items to differentiate between the nature of sexual assault/abuse and suicidal ideation and behaviours. Bensley et al (1999) for instance devised separate questions about suicide ideation, planning, non-injurious and injurious attempts. The sample consisted of 4,970 teenagers (8th, 10th and 12th graders). They found that abuse during childhood, in particular a combination of physical and sexual abuse, were strongly associated with suicide ideation and behaviours, even more so than either of those two separately. The level of

severity of the abuse was also associated with the severity of the suicidal behaviour, leading to more frequent attempts. As expected, girls reported more suicide ideation and non-injurious attempts than boys, and girls were more likely to declare their experience of sexual abuse.

The relationship between sexual abuse and suicidal ideation/behaviours is further demonstrated in a study by Ackard and Neumark-Sztainer (2002). Their study of 80,000 teenagers (9th and 12th graders) in Minnesota found that girls were more likely to have experienced suicidal ideation and attempts than boys and that this frequency was associated with child abuse, especially sexual. Other studies have also used separate screening questions for and found links between sexual assault and ideation and behaviours (Coker et al, 2000). Hibbard et al (1990) showed that sexual abuse was associated with a six times greater risk of suicide attempts. Other studies (Peters & Range, 1995; Thakkar et al, 2000) have also noted the contribution of child physical abuse and sexual abuse, either singularly or combined, as risk factors of suicide ideation and attempted suicide. Garnefski, Diekstra and deHeus (1992) also confirmed the link between sexual abuse and suicide in their study of 14,700 students aged 15 to 16 years, finding that for boys as well as girls, sexual abuse, depression, loneliness and low self-esteem were related to suicide ideation and suicide attempts.

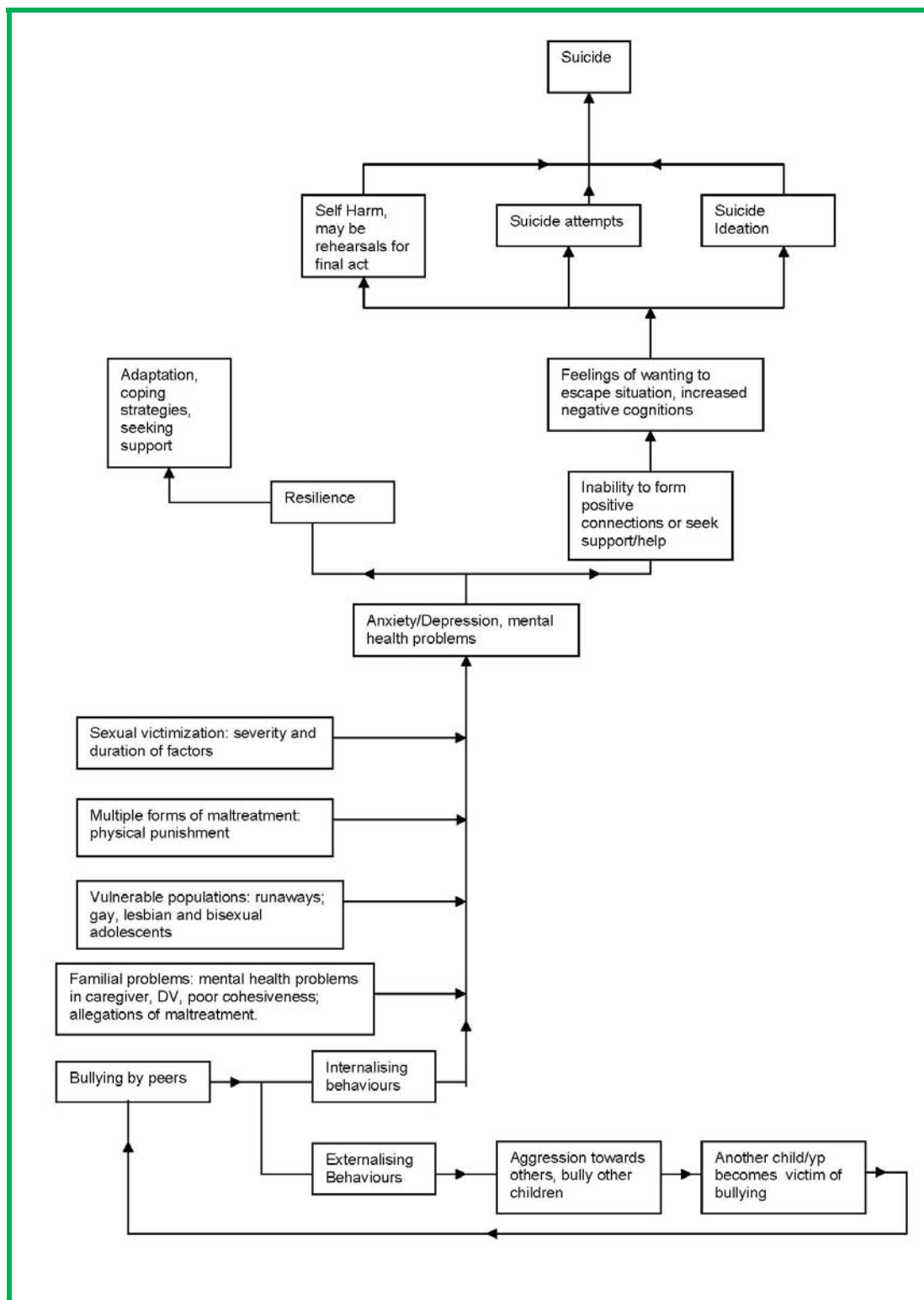
College samples also show links between sexual victimization and suicide ideation. In a study by Skepanoff (1998), suicidal ideation was associated with adult sexual assault but not child sexual abuse, while actual suicidal attempts were associated both with adult sexual assault and child sexual abuse. However, another study arrived at a different conclusion. In a sample of 494 female undergraduates, an association was found between suicide ideation and childhood abuse and adult partner violence, but not between childhood abuse and adult sexual assault (Nilsen & Conner, 2002).

Similarly, Thakkar et al (2000) studied suicide ideation in female college students. They found that suicide ideation was associated with both child physical and sexual abuse, but adult sexual assault was not. The frequency and severity of the abuse is also influential on the ideation/attempts. There are certain limitations of this study: firstly that the sample was largely middle-class, and therefore generalising to other populations may not be applicable. However, what can perhaps be deduced from these findings is the prevalence of suicide ideation among a largely middle class sample. It could be argued that the experiences or pressures of being raised within middle class ideals contributes to the overall stress an individual may feel if they have experienced sexual /physical abuse. The more prolonged and

severe the sexual abuse was associated with greater depression, lower self-esteem and more self-destructive behaviours in both college men and women (Boudewyn & Liam, 1995).

The nature and severity of the childhood abuse was examined by Peters and Range (1995). Examining the nature of childhood abuse in a sample of 266 male and female college students, the researchers found that sexual abuse in childhood that involved touching resulted in greater suicide ideation in early adulthood than other non-contact forms of sexual abuse. This finding was consistent regardless of whether the individual was male or female, and whether or not the individual had experienced abused by an adult or a peer. The authors suggest that sexual abuse that involves touching leads to a greater inability to form cognitive deterrents against suicidal ideation. If this is the case, it is an important contribution to understanding how the nature and extent of the abuse leads to potentially long-term psychological effects in an individual.

There will always be cases where sexual abuse in early childhood does not lead to suicidal thoughts in adolescence. Equally, there are many other factors which may lead a child to consider suicide apart from sexual abuse. A stress model takes all of these into account, where suicide is a result of a set of cumulative stressful factors that eventually cause a pathological response in the individual (Rubenstein et al, 1998). The merits of this model are that it includes all children and young people who have experienced stressful life events – of which sexual abuse may or may not be one - which led them to take their own life. This model also explains how various factors can be added and how they may interact with each other, as well as the protective elements of the individuals' environment that may prevent them from suicide.

Figure 2 Model of suicide risk factors

Source: Rubenstein et al, 1998

Rubenstein et al (1998) found no differences in terms of social class, marital discord, age or gender, between adolescents who were suicidal or non-suicidal. However, they did find that the suicidal group were more likely to engage in self-destructive behaviour, including self-harm and suicide attempts. These factors together with other areas of concern including: life stress, depression, sexuality, achievement pressure, loss and familial suicidality; made this suicidal sample of high school students directly comparable with hospitalised suicidal adolescents who were matched in terms of age, sex and social class. Both groups were equally depressed or stressed, experienced similar feelings of hopelessness and lower levels of school performance. Although depression was assessed for all adolescents, the researchers, unsurprisingly perhaps, found that suicidal adolescents had a mean BDI (Beck Depression Inventory) score of 16.95 compared to non-suicidal adolescents, for whom it was 7.57. The former fell into the clinically depressed range, whereas the non-suicidal adolescents did not. Similar patterns were observed for the measure of stress: the mean for suicidal adolescents was 12.90 while for non-suicidal adolescents it was 7.99. If adolescents had sexuality concerns, achievement pressure, or personal loss, these were likely to increase the risk of suicidal behaviour. If an adolescent had more than one of these factors, it was likely to increase the risk of suicidal behaviour even further. Protective features are likely to prevent suicide: if an adolescent perceives their peer relationships in a positive way and considers their family cohesive and adaptable, this decreases the chance of suicide. Practitioners may want to consider building this into their assessments and interventions (refer to section at the end of this paper on practice implications.)

4 School bullying and suicide

The media frequently report incidents of children who have allegedly been driven to commit suicide as a result of persistent bullying by school peers. Research conducted in America, South Korea, Norway and Sweden, has also reported a link between bullying at school and subsequent suicide (Carney, 2000; Wichstrom, 2000; Roland, 2002; Ivarsson et al, 2004; Kim et al, 2005; Burgess et al, 2006). A higher frequency of self-harm is also observed in young people (aged 15-16) who have been a victim of bullying (8.3 per cent) compared to those who have not (2.8 per cent), (Hawton et al, 2002)

Burgess et al (2006) provide a model of internalising and externalising behaviours as consequence of (repeated) bullying, differentiating between those who commit suicide and those who go on to bully others or engage in other life-threatening behaviours. They discuss

the differences and similarities between these two groups, asserting that a child or young person who has been bullied may either internalise their problems and become increasingly withdrawn, develop physical complaints and anxiety (potentially leading them to contemplate suicide), or externalise it, which can lead to aggressive behaviour towards other peers or substance abuse, which in extreme cases can have life threatening consequences. Burgess et al (2005) provide case studies of children and young people who were bullied by their peers to support this model, but it is worth pointing out that in all of these cases there were additional problems, as the following examples reveal.

One child experienced emotional and physical abuse at home and was bullied at school. The abuse suffered at home and at school went unnoticed and unreported. The boy later drowned a peer who apparently provoked him on a swimming trip. The incident was termed an accident and the boy confessed to this crime only later in life when he was arrested and convicted as a serial killer. This case illustrates externalising behaviour in a pathological way, targeting victims and concealing the crimes.

The second case Burgess et al (2005) describe involved a 12-year-old boy who was bullied, allegedly because he had a learning disability and slight physique. A charge of neglect was brought against his mother due to school absence and the boy's lack of hygiene, which were a consequence of the bullying and sense of low self-worth. His mother had frequently complained to the school about the bullying, but nothing was done. The boy may have experienced problems at home but it was the bullying that led him to internalise his problems and anxiety. He also had no peer support and was generally an outcast at the school. Teachers rarely intervened. He later committed suicide.

A third case is of a boy who was bullied on account of his alleged sexual orientation, as a result of which, in a desperate effort to regain his 'reputation', he returned to school with a gun. He shot and killed three people at his school and wounded five others. The authors do not provide details of this boy's home environment, so the circumstances can only be speculated upon. However, the case is another example of externalising behaviour as a consequence of being bullied at school.

Kim et al (2005) examined the frequency of suicidal ideation among victims and perpetrators of school bullying. The sample consisted of 1718 13- to 14-year-old students (8th grade). Forty per cent were either victims of bullying (14 per cent), or bullied others (17 per cent), or victims-turned perpetrators (9 per cent). A control group was compared with each of these

groups. This comparison identified higher rates of suicide ideation in the 'bullying groups' when compared to the control group. This finding was previously found in a study by Roland (2002) Roland further noted a trend in the data to suggest that suicide ideation was slightly greater in perpetrators than victims, but the finding was not statistically significant.

In another study of 201 students with an average age of 14, 48 per cent reported being victims of peer abuse and 52 percent that they had witnessed peer abuse (Carney, 2000). Carney examined the degree of empathy and understanding of the impact of bullying on other students who had themselves been victims and those who had merely been bystanders. Both groups showed empathy for the 'victim' of the bullying and recognised the impact of the bullying on their emotional welfare. Carney suggests that even bystanders are affected by witnessing peer abuse, and interventions should target not only victims and perpetrators, but also bystanders. Carney makes a powerful suggestion for future work, one of which is to consider the similarities between victims, perpetrators and bystanders by evaluating the characteristics of the school environment that give rise to these behaviours. An understanding of the environmental mechanisms that encourage or discourage bullying behaviour is the key to preventing bullying.

A study of junior school children (Ivarsson et al, 2005) reported that the prevalence of bullies was 18 per cent; victims 10 per cent and victim-perpetrator was nine per cent; still high in spite of the younger age group. The study indicated that bullies usually externalised their behaviour through aggression and delinquency; victim-perpetrators displayed a combination of externalising and internalising behaviours and victims were considered by the school health officer to have various psychiatric problems and poor social skills.

To conclude, bullying is a well-documented problem within schools. The studies mentioned above have reported a high incidence rate in junior and secondary schools. Whether a child or young person is a victim, perpetrator or bystander the effects of peer abuse are evident. However, suicide ideation is most common in victims and perpetrators. Prevention programs should consider bystanders and not just the victims and perpetrators. This would help to educate children about the effects of bullying whether they participate in it or not.

Further work needs to evaluate the school environment and mechanisms that mediate bullying behaviour. Finally, it should be noted that although the studies discussed above have shown a link between bullying behaviour and suicidal ideation, this does not prove a causal link between the behaviour and the outcome. Bullying may be one of many different factors

mediating in the lives of both victims and perpetrators. Therefore, an in depth study examining the other social and personal factors in the lives of both victims and perpetrators needs clarification.

5 Vulnerable populations & incidence rates

The association between types of abuse and self-harm/suicide is further exemplified by studies of medical/psychiatric patients. Law et al (1998) analysed a sample of 257 females aged between 18 and 50, who were admitted to hospital after an overdose. Among these women, sexual, physical and psychological forms of abuse were all associated with overdosing and other forms of self-harm. Seventy-two per cent of these women had experienced child sexual abuse. Those women who were serial attempters had experienced child sexual abuse for longer periods, and had experienced sexual assault as an adult (Coll et al, 1998). Gould et al (1994) found that females reported more sexual and physical abuse, and that this was related to increased risk of suicidal behaviour. Women in primary care who experienced both sexual and physical abuse in childhood were more likely to have attempted suicide or reported current suicidal ideation than non-abused patients (McCauley et al, 1997).

The research conducted on clinical samples within the UK showed that relationship problems and the perceived insoluble nature of these problems were the main cause of self-harm and suicide attempts (Milnes, 2002). This research unfortunately did not examine the subject of sexual abuse or other forms of abuse and their association with suicide or suicidal behaviours

It is worth noting at this point that psychiatric patients upon discharge from hospital for self-harming are more likely to self-harm again within the following 12 months. Thirty-three per cent of those who self-harm again do so within the first three months of discharge (Gunnell et al, 2008). It is therefore clear that this population is particularly vulnerable to repeated self-harm, which calls for closer monitoring and the design of more effective prevention strategies.

Some research has identified higher rates of suicide ideation among samples of runaways. Shaffer and Caton (1983) for instance found suicide ideation a feature among 33 per cent of adolescent runaway/homeless girls and 16 per cent of boys. Molnar et al (1998) also noted elevated levels of suicide attempt and suicide ideation among runaway/homeless adolescents. A study by Molnar et al (1998) of runaways found that 48 per cent of females and 27 per cent

of males had attempted suicide. Furthermore, 70 per cent of females and 24 per cent of males had experienced sexual abuse; physical abuse levels were the same for males and females (35 per cent). The presence of this abuse prior to leaving home was a significant predictor of suicide attempts.

Sexuality problems are relevant as a risk factor in studying suicide ideation in gay, lesbian and bisexual adolescents. Proctor and Groze (1994) identified prevalence rates of suicide ideation as high as 66.1 per cent in these groups. The researchers explain the findings in terms of the inability of some gay, lesbian and bisexual adolescents to cope with the discrimination, loneliness and isolation they face because of their sexuality; whereas others have support from their peers/ families and community. Concern about sexual orientation was also shown to be more frequent among young people who engaged in self-harm (11 per cent) compared to those who did not have such worries (3 per cent) in a study by Hawton et al (2002).

Finally, there is evidence to suggest that there is an association between suicide and self-harm in young people who are exposed to substance misuse (Hawton et al, 1993; Gunnell et al, 2008). It is therefore recommended that practitioners working with these vulnerable young people employ drug prevention strategies as part of their intervention together with the prevention of self-harming/suicide.

6 Developmental considerations

Rubenstein et al (1989) drew attention to certain factors in adolescence that make an individual more susceptible to suicidal behaviour. These were concerns over sexuality, personal loss and pressure to achieve. This is further supported by research conducted by the Samaritans (Samaritans, 2001, 2002) who noticed the increased incidence of depression among adolescents in relation to these factors. Rubenstein et al (1989) conclude that these are key factors that become important to an individual during adolescence, and this is why there is an increase in suicidal behaviour in adolescence as opposed to childhood. However some research has been conducted with young populations regarding suicidal behaviour. Thompson et al found that 9.9 per cent of eight-year-olds had suicide ideation. Their preoccupation with these pathological cognitions was associated with the severity of maltreatment and physical abuse. If there were multiple forms of maltreatment this was likely to increase the risk of suicidal behaviour. A number of factors aside from maltreatment were

examined. These included demographic data, familial factors and child-functioning (defined by the authors as: psychological distress, substance use and social problem solving skills). Various types of family problems were identified, such as mental health problems of caregiver(s); witnessing family violence; poor cohesiveness; allegations of maltreatment and multiple transitions in a child's living situation. The child's psychological functioning was examined and certain factors were identified in relation to suicide ideation. These included: psychological distress; substance use; need for mental health services and poor academic performance. The results showed that suicide ideation was more frequent among white middle-class children. Overall children who experienced maltreatment were twice as prone to suicide ideation compared to children who had not, and a particularly strong indicator was witnessing or experiencing violence within the family. The authors suspect that the finding that white children were more likely to experience suicide ideation than African American children is that the latter may have certain cultural or religious factors that may protect them from suicide ideation. However these children may also express their problems in other ways.

Further support for differences between white and other ethnic groups regarding the prevalence of suicidal behaviours/ attempts was shown in the study by Meltzer et al (2001). The research was based upon a survey with parents of and children aged between 11-15 years, examining the incidence of self-harm and suicidal behaviours. Parents were asked to report whether or not their child had self-harmed or tried to kill themselves and the parental report was compared with that of the child. The demographics of the sample were shown in table 2 below, together with the source of the information, i.e. if it was from the parent, child or a combined statistic for the two groups. The sample showed that self-harm and suicidal behaviour was higher in white children and adolescents than those from other ethnic groups for both the parental report and that of the child. It is also worth noting at this point, that self-harm is also more common among white young people than other ethnic groups (Hawton et al, 2002). Meltzer et al, (2001) noted a more varied distribution for social class, however it should be noted that children reported a higher incidence than parents did. This may be due to the secretive nature of this sensitive issue and parents may have either been unaware of their child participating in such behaviours or perhaps they were uncomfortable about admitting their child engaged in this behaviour.

Table 2 Demographic details of parents and children who reported self-harm, suicidal thoughts / attempts

	Report of parent of child aged 11-15		Report of child aged 11-15		Report of parent or of child aged 11-15	
	%	n	%	n	%	n
Social class						
I	2.6	257	4.9	329	6.6	348
II	1.8	1,471	6.7	1,401	7.3	1,472
III Non manual	1.1	545	5.1	513	5.5	545
III Manual	1.7	1,111	6.0	1,055	6.7	1,112
IV	2.9	654	5.9	596	6.9	654
V	2.5	242	5.0	218	6.6	243
Never worked	5.0	60	1.9	54	6.7	60
Ethnicity						
White	2.2	4,148	5.7	3,907	6.6	4,166
Non White	1.3	381	7.0	412	7.1	435

Source: Meltzer et al (2001)

Meltzer et al (2001) also examined other factors in the child's life that may contribute to suicidal behaviours. The study found that 17.5 per cent of children who reported suicidal behaviours had experienced five or more stressful life events. Furthermore 7.7 per cent of children who had suicidal behaviours also experienced frequent punitive regimes at home. Finally, 37.5 per cent of children who showed suicidal behaviours also predominantly reported having depression.

7 The role of the media and the Internet

A recent examination of search engine results for suicide revealed the number of websites that appeared to support and promote suicide (Biddle et al, 2008). The study revealed that not only were these sites readily accessible but also there were sites that described various methods for suicide. There were other sites available to provide information on services that could help prevent suicide, but there is a risk that children and young people can access these more controversial sites at a time when they are feeling particularly vulnerable. In Australia, it is illegal to promote the idea of suicide on the internet, but there is no such legislation in the UK. Biddle et al (2008) suggest that service providers operate better self-regulation and parents use filtering software to prohibit access to these sites.

The internet allows for chat rooms to develop, where there can be an exchange of ideas. This can give rise to suicide pacts, although these are extremely rare. A suicide pact is an agreement between two or more people to commit suicide in a specific place at a specific time (Rajagopal, 2004). However, the definition can be much broader than it is in England and Wales, where people who have committed suicide within three days of each other and who live in the same district are considered potential victims of a suicide pact (Brown & Barraclough, 1997). Between 1988 and 1992, there was about one case of a suicide pact per month and they account for 0.6 per cent of all suicides. Also, the demographics of those who participate in suicide pacts tend to be older, female, married and of high social class (Brown & Barraclough, 1997). This is in contrast to those who commit suicide alone, who tend to be in early adulthood (ONS, 1974-2000).

In 2007/08, 17 young people committed suicide in the county borough of Bridgend, an area of 285 square kilometres in South Wales with a total population of around 130,000 people. There were suggestions that this was an internet-inspired suicide pact. However, following police investigation, it appears that this was not the case.

It has been argued that suicide pacts are characterised by a psychiatric disorder called 'folie a deux'. This is a delusional disorder shared by small groups of individuals. These groups can adhere to these delusional beliefs, and are often isolated from the rest of society (Salih, 1981). The use of the internet, as a means of communication between individuals, may play a role in this. However, there is an absence of research examining the 'cybersuicides'.

Normalising suicidal behaviour, or at least the methods, is facilitated to some extent by the role of the media. There was a case in Hong Kong where a woman committed suicide by burning charcoal in a sealed room. The case was reported in the media and as a consequence a third of all subsequent suicides were by this method, as opposed to jumping from a great height, which was the most common method up until this point (Chan et al, 2003). Similar factors have been noticed in the UK, with epidemics following the reporting of certain suicide methods in the media (Hawton & Williams, 2002; Biddle et al, 2008). It has also been noted that the media can raise public awareness: for example, after a character in a soap opera went for a cervical screening and was discovered to have cancer, there was a 21 per cent increase in women seeking cervical screening in that particular year as opposed to the previous year (Howe et al, 2003; Hawton & Williams, 2002).

8 Recommendations for future research and practice

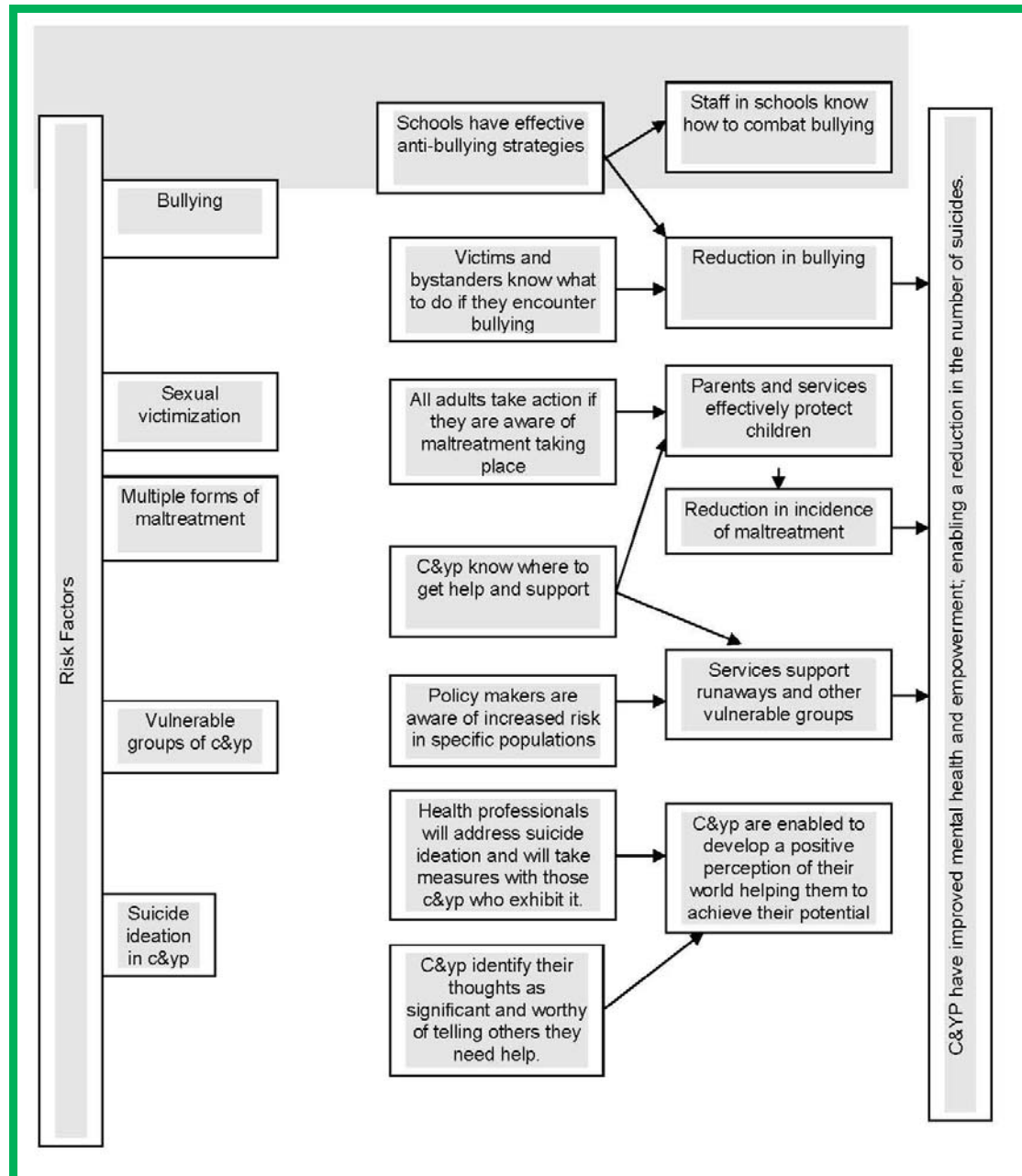
1. Research needs to consider the environmental or individual mechanisms that operate within a school environment that encourage or discourage bullying. Research also needs to consider in more detail the similarities and differences between victims, perpetrators and bystanders and the choices they make about whether to engage in bullying or not.
2. Bullying may be one of many different factors mediating in the lives of both victims and perpetrators. There needs to be an in-depth study examining the other social and personal factors in the lives of both victims and perpetrators and the contribution they make to suicide ideation.
3. For assessment purposes, a practitioner may want to consider more closely how an adolescent perceives their peer relationships. If an adolescent perceives their peer relationships in a positive way and considers their family cohesive and adaptable, this decreases the chance of the individual attempting suicide.
4. Practitioners may also want to consider routinely screening for suicide early on in their assessment, rather than avoiding the subject until the individual voluntarily discloses their thoughts during the course of therapeutic intervention. This may be a more proactive way of engaging the individual and deterring subsequent suicide attempts.
5. Practitioners also need to consider the relationship between self-harm and suicide. The practitioner needs to consider whether the act of self-harming is a sufficient release for the individual or whether there is a risk of self-harming with suicidal intent.
6. During the assessment period, the practitioner should consider the contributory role of sexual abuse in cases of attempted suicide and suicide ideation. This may enable a greater understanding about which factors surrounding the nature and extent of sexual abuse lead to such a detrimental effect on the human psyche in later life.
7. Due to the link between substance misuse and self-harm and suicide, it is recommended that practitioners working with these vulnerable young people examine ways of

employing drug prevention strategies as part of their intervention together with the prevention of self-harming and suicide.

8. Vulnerable populations such as psychiatric patients need to be closely monitored, as they are particularly prone to self-harming within 12 months after discharge from hospital, with many harming themselves within the first three months. Effective prevention strategies need to be developed to help this group of individuals.
9. There needs to be more research conducted in the UK on this sensitive issue and explore the association between sexual abuse and subsequent suicide.
10. Parents need to be aware of the websites their children are visiting and install software to prevent access to certain parts of the internet. Internet service providers need to have better self-regulation and the media need to understand the influence it has upon the population's behaviour and take responsibility for this.

Figure 3 (below) summarises the risk factors that can lead to suicide and the measures that can reduce the impact of these factors, lowering the incidence of suicide.

Figure 3 Model of suicide prevention



Conclusions

To conclude, suicide ideation is a common feature of children and young people who have experienced maltreatment or are at risk of maltreatment. These children often experience many different problems and are unable to make positive connections with peers or others to help them build some sort of resilience. It is advisable for all those working with children and young people who have experienced maltreatment to screen for suicide ideation routinely.

Incidence rates show that suicide ideation and suicide attempts are more prevalent in vulnerable groups. Children as young as eight have shown suicide-ideation, but mortality figures indicate that recorded attempts of suicide only increase after the age of 10. This may mean that when children as young as eight commit suicide it is not recorded as such, or it could be that these children wait until adolescence to attempt suicide.

There is a need to research the time between the nature and extent of abuse occurring and the subsequent suicide ideation. Understanding the chronology of events in a person's life would enable a greater understanding as to why the suicide attempt occurs. There are differing findings on this issue. Hawton & Harriss (2008) suggested that repeated self-harm resulted in a low long-term risk of suicide; Zahl & Hawton (2004), on the other hand, found that repeated self-harming indicated a greater risk of suicide than a single self-harming event. This may be due to the age difference of the samples used in each study: a lower age group was used in the former (12-14) compared to the latter (10-24). The latter sample also had a higher prevalence of self-harming history (39 per cent) than the former sample (26.8 per cent), which may have influenced the results.

There are strong links between various types of abuse - particularly sexual abuse and bullying - and suicide attempts. The intensity and duration of the abuse has a direct bearing on the severity and persistence of suicide ideation and suicide attempts.

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