Review

Aggression, Suicide, and Self-Harm in Children and Adolescents

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Abstract

Suicide is the second leading cause of death among adolescents in the age group of 15 to 19 years. As per the National Crime Record Bureau, India loses 1 student to suicide every hour. The COVID pandemic saw an alarming rise in the number of children/adolescents attempting suicide. The state of Kerala lost 173 children in the age group of 10 to 18 years, during the first wave of the pandemic (March-October 2020). This review article has been written with the aim of exploring causes of aggression, suicide, and self-harm in children and adolescents. It also strives to bring forth the various interventions which can be taken in order to reduce the rate of suicide and self-harm in children and adolescents.

Keywords

Adolescents, children, self-harm, suicide

Introduction

Among adolescents in the age group of 15 to 19 years, suicide is the second leading cause of death.[1] From a developmental outlook, suicidal ideation is very rare before 10 years of age, increases gradually through age 12 years, and subsequently accelerates through the age of 17 years.[2] India unfortunately has the highest suicide rate in females belonging to the age group of 10 to 19 years (15 per 1,00,000).[3] As per the National Crime Record Bureau, every hour a student dies by suicide in India.[4]

As per the Youth Risk Behavior Survey conducted in the United States, 17% of high school students (grades 9–12) reported that they had seriously considered suicide in the past year. The rates were higher among female than male students (22% vs 12%).[1]

The COVID pandemic saw an increase in the number of children/adolescents attempting suicide. The state of Kerala lost 173 children in the age group of 10 to 18 years, during the first wave of the pandemic (March-October 2020). Additionally, there was a 9.3% to 33% hike in the number of children/adolescents having self-injurious behavior.[5]

This review article has been written with the aim of exploring causes of aggression, suicide, and self-harm in children and adolescents, with a special emphasis on emotional dysregulation. It also aims to highlight the various interventions which can be taken in order to reverse the above statistics.

Emotional Dysregulation and Self-Harm

Emotional dysregulation has been found to be a common underlying factor in various studies examining suicidality in children and adolescents. In a study done by Trigylidas et al[6], assessing children with certain mental disorders who died by suicide, it was found that depression was existing in 40.8%, attention-deficit/hyperactivity disorder in 20.6%, oppositional

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defiant disorder/conduct disorder in 20.1%, and bipolar disorder in 16.3% of the children.

The child behavior checklist-dysregulation profile (CBCL-DP) compares adolescent self-harm behavior, suicidal ideation, and suicidal behaviors with the general public. Dysregulation was reported by parents and youth on the CBCL. Both parent-reported as well as youth-related dysregulation were positively related to self-harm and suicidal ideation reported by adolescents. Community studies have demonstrated that youth having a higher CBCL-DP score in their childhood had a greater predisposition for suicidality in adulthood.[1,7]

A study done by Selby et al[7] on youths hospitalized for increased suicide risk found that the previous week's levels of emotional and behavioral dysregulation were significant predictors of the following weeks' degree of suicidal ideation. Studies have also shown that emotional sensitivity and peer invalidation are significant positive as well as prospective predictors of elevated suicidal ideation over the next 6 months. This data indicates that emotional and behavioral dysregulation are related to suicidal ideation over an acute phase (over weeks) as well as chronic phase (over months), highlighting the importance of their early detection and intervention.[1]

Anger dysregulation has also been found to predict suicidal ideation strongly. In a prospective study done by Daniel et al,[8] the State-Trait Anger Expression Inventory (STAXI) was administered to 180 adolescent indoor patients. It was found that higher trait and expressed anger were associated with increased tendency of suicide attempts even after 13 years post discharge. In girls, anger trait and the internal/external expression of anger was found to increase the risk for suicide attempts, only when associated with major depression. For boys, it was found that the diagnosis was not contributory.[8] Overall, both male and female students at high risk for suicidal ideation were found to have greater rates of state and trait anger on the STAXI.[8,9]

Apart from anger, irritability has also been found to have a strong association with suicidality. Psychological autopsies of youth showed that emotional and behavioral disturbances associated with irritability are frequently reported during the period prior to the suicidal act.[1] Orri and colleagues followed approximately 1,400 youth prospectively from birth to the age of 17 years. They used children, self-reported measures of mental health symptoms and suicidality, from 13 to 17 years of age and teacher assessments of irritability (defined by tantrums and aggressive responding to provocation) yearly from 6 to 12 years of age. Children with either a rising or consistent irritability trajectory (vs a low trajectory) were at an elevated suicidal risk.[10]

Benton et al[1] have proposed that suicidal attempts and behavior may be similar to self-injurious behaviors as they may be undertaken in order to reduce intolerable affective states and probably have reinforcing properties. In the beginning, suicidal behavior may reduce emotional dysregulation, while in the future it may ultimately increase negative emotions and itself pose as a stressor.

Aggression in Children

From a developmental perspective, young children commonly use aggression to express their feelings before entering school. This is termed as "instrumental aggression." It does not generally persist unless it is perpetuated due to the child-environment interplay. When parents fail to train their toddlers to interact within an accepted range of compliance, the aggression may later pave the wave for delinquency or serious antisocial behavior. For a child exhibiting aggression, the transition to elementary school indicates a significant developmental milestone. If in primary and secondary school, the teachers fail to inculcate emotional regulation practices, the coercive pattern seen in the home will persist in school and hence perpetuate.[11] Unmanaged aggression can later also impact academic performance and lead to externalizing syndromes. Hence, it is imperative to address it in the early stages via parent and school mediated interventions, which will be discussed in the later sections of this review.

Self-Harm and Suicidality

Suicidal behavior has been known to exist on a spectrum, ranging from occasional suicidal ideas to a well-deliberated completed suicide. Studies have shown that the chances of a completed suicide are 10-fold higher in children/adolescents having a previous attempt.[12]

Risk Factors for Suicide

Indian studies have found many risk factors for suicidal behavior, namely: belonging to the Hindu religion, older adolescents, female gender, working for finances after school/college hours, academic difficulties, strained family dynamics, failure in romantic relationships, history of suicide by a friend/family member, death of parent(s) by suicide, physical illness, and parental psychiatric psychopathology. In a study done by Grover et al[13] on 101 children and adolescents referred to consultation liaison psychiatry services in view of deliberate self-harm attempts, it was found that self-harm was higher in children belonging to nuclear families, reflecting a lack of emotional support being a significant risk factor.[13]

Role of Parenting Styles

Parenting styles are attitudes and behaviors that parents incorporate across various settings, in order to handle their

children's behavior. It comprises of control patterns, punishment, responsiveness, and warmth. It is a well-established fact that parenting styles greatly impact a child's overall development and often predict the onset of internalizing and externalizing behaviors. In a review done by Sahithya et al,[14] it was found that punitive styles comprising of spanking and physical corrective measures were associated with higher rates of child disruptive behaviors, aggression, and bullying. On the other hand, parental warmth seemed to buffer the effects of harsh parenting.

In a cross-sectional study done my McKee et al[15] on 2,582 parents and their children (5^{th}/6^{th} grade), it was found that harsh discipline was associated with aggression and bullying. A cross-sectional study conducted on 112 boys between 33 and 37 months of age and their parents, by Van Aken et al,[16] found that psychological control had a positive relation with aggressive behaviors in the toddlers. A longitudinal study done by Hoeve et al[17] on 330 Dutch families having adolescents and young adults found that neglectful parenting styles were related to an increased tendency of delinquent behavior in males. The same study found that permissive parenting was related with delinquent behavior in females. A cross-sectional study by Rinaldi and Howe[18] on 59 parents of toddlers showed that permissive parenting style of mothers and authoritarian parenting styles of fathers were strong predictors of externalizing behaviors in their toddlers.[18] In a cross-sectional study by Martinez et al[19] on 673 Spanish adolescents aged 14 to 17 years, authoritarian parenting was recognized as a risk factor for drug abuse, delinquent behavior, and misdemeanor in the school setting.

Zaborskis et al[20] in their cross-sectional study on 3,572 teenagers in the 13 to 15 years age group found that an authoritarian and repressive parenting style in the father and a permissive parenting style in the mother were strong predictors of suicidality and suicidal attempts in their offspring. A cross-sectional analysis done by Gómez-Ortiz et al[21] on 2,060 high school students showed that authoritarian parenting styles increased the chances of an adolescent to be involved in bullying.

Indian studies have also shown similar findings as studies done in the Western setting. A cross-sectional comparative study done on hundred delinquents and hundred nondelinquents by Moitra and Mukherjee[22] showed that neglectful or authoritarian parenting was positively related to delinquent activities. In a study done by Singh et al[23] on 436 undergraduates, it was found that hopelessness, trauma, and higher suicidal ideation were present in youth with affectionless control and neglectful parenting. A cross-sectional analysis on 100 students by Moudgil and Mukherjee[24] found that there was a significant positive correlation between childhood aggression and authoritarian parenting by the mother. It further found a significant negative correlation with aggression in the child and flexible parenting by the father.[24] In a cross-sectional study by Kumari and Kang[25] on 400 adolescents, it was found that warm parenting along with a supportive and accepting environment were associated with reduced instances of aggressive behavior in the child.

Role of Media

Media is a double-edged sword indeed and the pandemic brought this fact to light even better. On the one hand, we had children struggling with technology and trying to access virtual means of education, while on the other hand, those with very easy access started to develop screen addiction. The instances of cyberbullying have increased significantly since the pandemic. Since the internet almost always leaves a permanent trail, the impact of cyberbullying on a young developing mind is long lasting and can scar one for life. In a study done by Maurya et al,[26] obtaining data from the "Understanding the Lives of Adolescents and Young Adults" (UDAYA- 2015–16 and 2018–19)[27] surveys conducted in Uttar Pradesh and Bihar, it was found that adolescents who were victims of cyberbullying were at 2.50 times higher risk of having suicidal ideation than those who did not (4,428 males and 11,864 female cohorts).

Suicide clustering has also been observed due to rapid news spread, often disregarding the norms of suicide reporting.

Role of Schools/Teachers

Children/Adolescents normally spend half of their day at schools/colleges. This makes it even more imperative to ensure suicide prevention strategies are taken up by educational institutes. Often exams, classroom bullying, and groupism can take a nasty turn and lead to self-harm in children.

While the COVID pandemic brought to the forefront cyberbullying and difficulty being faced by children to cope up with online education on the one hand, it also shed a light on children from economically disadvantaged sections being deprived to virtual means of education. A review done by Khadse et al,[28] analyzing media reports of students attempting suicide during the pandemic, highlighted the following themes: (a) difficulty in accessing online education, (b) difficulty in coping with virtual education, and (c) being reprimanded by the parents.

The SEHER trial from India found that having interventions by a lay counsellor in the school setting reduced bullying as well as the severity of depressive symptoms.[3,29]

In view of the above, educational institutes should address suicide prevention on a priority basis. Teachers should receive training to recognize and cater to the emotional requirements of vulnerable pupils, such as those taking board exams. In order to lessen students' stress, educational institutions should

be flexible with regard to attendance, finishing the curriculum, and holding exams.

Classroom Programs

The Incredible years-Teachers Classroom Management Program (IY TCM) is an evidence-based prevention program formulated to coach teachers in fruitful classroom management methods, thereby decreasing the instances of disruptive behaviors and aggression in students. It is used extensively in the United States. It works with educators to enhance their capabilities in classroom management and to reinforce home-school collaborations in the following areas: (a) efficacious classroom handling skills; (b) social and emotional training of students; (c) developing a positive student-teacher bond; (d) using suitable discipline strategies; (e) collaborating with caregivers; (f) teaching effective social skills, anger management strategies, and problem-solving skills in the classroom; and (g) reducing the degree of classroom aggression.

In a study done by Chuang et al[11] on 105 teachers and 1,817 students from kindergarten to third grade across 9 elementary schools, to assess the benefit of the IY TCM program, it was found that children with aggressive behaviors were benefitted from the targeted interventions entailing social-emotional coaching. The program had several positive outcomes-better math skills, prosocial behaviors, better emotional regulation, and a reduction in observed aggression.

Genetics and Neurobiological Correlates

Genetic factors play a major role in familial transmission of suicidality, with an estimated 30% to 50% heritability of suicidal behavior.

Due to its involvement in depression and aggression, the serotonergic system has been the most analyzed with respect to suicidal behavior. Low levels of 5-HIAA (main metabolite of serotonin) were found in the cerebrospinal fluid and plasma of adults and adolescents with suicidal behavior. Polymorphisms in 5-HTTLPR (serotonin transporter gene) have been found in individuals exhibiting suicidal behavior. While exploring teenage deaths, it was found that the expression of serotonin 5-HT(2A) receptor was higher (postmortem analysis) in those having died by suicide, when compared to other causes. Reduced neuroplasticity has also been found in suicidal individuals. This impedes their positive coping mechanisms and leads to deficits in attention, learning, memory, and decision-making. It can also manifest in the form of ideas of hopelessness. Brain-derived neurotropic factor (BDNF) Va166Met polymorphism has been associated with an enhanced risk for suicidal behavior in Asian and Caucasian populations. Reduced plasma BDNF levels have been associated with suicidal behaviours.[3]

Suicide Risk Assessment in the CAMH Setting

The first and foremost step is to establish a rapport with the child. Various risk assessment scales can be used to identify the risk in a child/adolescent presenting with self-harm/suicidal behavior. The Columbia Suicide Severity Rating Scale (C-SSRS)[30] is a commonly used scale to assess suicide severity. The Ask Suicide-Screening Questions (ASQ)[31] tool consists of 4 short questions screening for suicidal ideation. It takes 20 seconds to administer. But in the acute setting, applying a scale may not always be possible, in the interest of time. Hence, clinical assessment and judgement may take precedence.

Interventions

1. Individual-focused interventions

Psychotherapy has been the mainstay to address self-harm ideas and suicidality in children and adolescents, which helps with emotional dysregulation. The various modalities are as follows:

a. Cognitive behavior therapy for suicide prevention (CBT-SP)

It combines aspects of CBT for depression (eg, cognitive restructuring and behavioral activation) along with elements of dialectical behavior therapy-adolescents (DBT-A) for emotional regulation. It aims to target emotional dysregulation via various regulatory skills such as relaxation, mindfulness, emotion identification, and hope building. Emphasis is also laid on involving family members and securing their cooperation, which is a key to ensure better prognosis.[1,32,33]

b. Interpersonal therapy

It focuses on the impact of their relationships on their mental/emotional well-being and overall functioning. Additionally, importance is laid on developing skills to regulate emotions and enhance emotional intelligence. Adolescents are taught about identifying emotions, monitoring their moods, and expressing their feelings in a regulated manner.[1]

c. Dialectical behavior therapy for adolescents

It includes individual therapy, skills training group, phone coaching, psychopharmacotherapy, school meetings/phone contact, family therapy, and telephone consultation for family members on using skills. It has shown to have good results for emotional dysregulation and suicidal ideation in adolescents.[1]

2. Family-focused interventions

Family interventions have a significant role to play in aggression, self-harm, and suicidal ideation in children and adolescents

as family dysfunction is often one of the stressors or perpetuating factors. In various meta-analyses and reviews of interventions for youth with suicidal behaviors, it was found that therapies/interventions having family involvement had robust evidence of efficacy in managing suicidal behaviors.[1]

Some family-based interventions which have shown to be effective are:

a. Attachment-based family therapy

It is based on the attachment theory. It teaches interpersonal and emotional regulation skills in order to enhance parent-child/adolescent relationships.[1]

b. Safe alternatives for teens and youths (SAFETY)

This is a cognitive-behavioral family treatment that is based on DBT and is specifically structured to reduce suicide attempts. It works to create a protective and safe space in the family environment and inculcate skills which promote safer behaviors during stressors.[1] In studies, the SAFETY program has been shown to decrease suicidal ideation and mitigate attempts in high-risk individuals.[34]

3. Pharmacotherapy

Pharmacotherapy is directed towards the underlying cause of suicidality/aggression. SSRIs are used for depression, mood stabilizers/low dose antipsychotics for mood disorders, and stimulants for attention-deficit/hyperactivity disorder.

Preventive strategies

The safety planning intervention, developed by Stanley and Brown,[32] can be used in children and adolescents with suicidal behavior, in order to help them manage themselves till professional help is available. Since it is made with the child, taking his/her/their strengths into account, it is easier for them to apply be a more acceptable plan. For children, it may be worthwhile to conduct the whole program in the presence of their parents/caregivers, as they may need more support in implementing the same. It involves the following steps:

Step 1: Generating a specific list of individual warning signs (eg, thoughts, behaviors, circumstances, emotional states) that usually occur prior to a suicidal crisis. Eg, fight with significant other/exams/test results.

Step 2: Creating a list of coping strategies that the child can implement on their own in the event of a suicidal crisis. Eg, watching a certain television show or movie, listening to some music, doing assignments, practicing a sport, instrument, or other hobby. These techniques should be able to distract the child in a positive way and not worsen the situation. For instance, watching a gloomy show/listening to sad songs may worsen the mood and intensify the ideation.

Step 3: Preparing a list of people or social settings that can serve as distractors from the suicidal crisis/thoughts. It has been seen that children may relate more to their friends and hence list them here, although some may list adults who could serve as good distractors. Social media may not always be a good setting for distraction, as the youth may be subjected to negative content/cyberbullying which can be detrimental in this setting.

Step 4: Preparing a list of individuals who can be approached for help in the event of a suicidal crisis. This should comprise of *only* those adults with whom the children/adolescents trust and with whom they have a nourishing/positive/healthy relationship. Eg, siblings/parents/teachers/caregivers/mentors.

Step 5: Professional resources the youth can contact. A list of functional suicide helpline numbers can be given, in the event of a crises.

Step 6: It involves making the surroundings safe and curtailing the access to dangerous/lethal means. Healthcare professionals should work collaboratively with children and their caregivers/trusted adults who can help in safeguarding their surroundings.[35]

The Road Ahead

Addressing aggression and self-harm in children is the need of the hour and the rates are increasing with every passing year. As mental health professionals, it is our responsibility to take up preventive programs to mitigate this burning issue. Awareness programs and talks for parents, teachers, and students can be conducted by liaison with various educational institutes. Red-flag signs need to be explained to the public at large so that timely interventions can be provided to those in need. Suicide gate-keeper training programs/courses can be used effectively so that help is accessible till the child reaches a professional. Given the large population of our country, these programs will ensure that help reaches those in far-flung areas. In order to appeal to the generation "Z," one can also make use of social media and create content which can be spread over a large audience. It is important to address myths as well, as there is a large amount of misinformation across the social media network and fake accounts who claim to help children but are using them for their own malicious interests. Hence, it becomes our professional responsibility to be accessible to the youth, so that they take help from the correct sources. The journey is indeed very arduous, but every step counts, if taken in the right direction.

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