

Editorial: Progress and Challenges in Characterizing Psychiatric Symptoms and Behaviors in Suicidal Preadolescent Children

Richard T. Liu, PhD 

Historically, little clinical and research attention has been focused on suicide in preadolescent children because of the commonly held view that children at this age do not possess the cognitive capacity fully to comprehend death (eg, its finality) and therefore are incapable of experiencing suicidal thoughts and behaviors.¹ This view may result in expressions of suicidal thoughts by preadolescent children being interpreted and treated as momentary expressions of distress, but not of actual desire or intent to engage in suicidal behavior. There is accumulating evidence, however, to urge caution against such an interpretation. Although preadolescent suicide occurs at a low base rate, it has been increasing, rising from the 10th leading cause of death in this age group in 2008 to the 5th leading cause of death by 2019 in the United States according to data from the US Centers for Disease Control and Prevention.² Furthermore, in the general community, suicidal thoughts and behaviors have been found to occur at concerning high rates among preadolescent children in a recent systematic review, with lifetime prevalence of 2.6% for suicide attempts and 15.1% for suicidal thoughts.³ In this age group, another form of self-injurious thoughts and behaviors (SITBs), nonsuicidal self-injury (ie, deliberate self-harm in the absence of suicidal intent), is also poorly understood and a significant concern, with a lifetime prevalence of 6.3% among preadolescent children in the general community. Accurate characterization of the psychiatric symptom and behavioral profiles of preadolescents with SITBs is an important step toward identifying children in need of intervention or preventive efforts to avoid these outcomes.

Toward this end, in the current issue of the *Journal*, Ayer *et al.*⁴ employed a statistical technique—latent profile analysis—designed to identify subgroups of individuals with shared characteristics of interest. Specifically, they applied this approach to a sample of 1,656 children ages 6 through

12 who had experienced SITBs based on caregiver report. In their analyses, they identified 4 subgroups of preadolescent children with SITBs based on parent report of their psychiatric symptoms and behaviors on the Child Behavior Checklist. Of children with SITBs, 39.7% were identified as having relatively low levels of psychiatric problems; 42.6% were identified as having mild problems; 15.4% were identified as having moderate problems; and 2.3% were identified as having a high level of severity across all psychiatric symptoms and behaviors, particularly ones involving rule breaking and thought problems (eg, obsessive thoughts and hallucinations). The proportion of each group that had both self-injurious thoughts and self-injurious behaviors increased with group severity. Nonetheless, it was notable that the preadolescent children with SITBs in the lowest severity group did not differ appreciably in terms of psychiatric symptoms and behaviors from a separate group of children without SITBs drawn from the same population.

The finding that rule-breaking behaviors may be particularly characteristic of preadolescents with SITBs is generally consistent with the view in the field that externalizing psychiatric symptoms may be especially relevant to suicidal thoughts and behaviors in this age group, in contrast to depression in the case of these outcomes in adolescence.⁵ Worth noting too, however, is that internalizing symptoms were also highest in the severe group with highest rates of both self-injurious thoughts and self-injurious behaviors, a finding that seems to run counter to this perspective. Yet, it is also consistent with meta-analytic findings of depression being most strongly associated, among all examined forms of psychopathology, with preadolescent suicidal thoughts and behaviors.³ Collectively, these findings may suggest a need for refinement of the aforementioned popular view of depression and suicidal thoughts and behaviors in preadolescent children; rather

than depression being diminished in relation to these outcomes with the heightened importance of externalizing behaviors in preadolescents, depression and externalizing psychopathology may both be highly relevant.

A unique strength of this study is its large sample of children with SITBs drawn from 42 societies around the world, which enhances generalizability of its findings. Even with their large sample, however, it was not possible for the authors to conduct latent profile analysis within individual societies or cultural groups, a challenge given the relatively large sample required to conduct this type of analysis coupled with the low rate of SITBs (3.5%) found in the study's assessment period (ie, past 6 months). As mentioned by the authors, this leaves open the possibility that different latent profiles with unique patterns of psychiatric symptoms and behaviors may emerge among preadolescents with SITBs within specific cultural groups. Given the historic lack of sociodemographic diversity in suicide research⁶ and psychiatry more broadly (eg,⁷), the need for future work to assess this possibility is strong, despite the challenge of conducting studies with an adequately large sample for analysis. To the extent that population-specific analyses with historically underrepresented groups yield findings that more accurately and uniquely reflect these populations, such work may serve a critical role in reducing disparities in the ability to assess, treat, and prevent SITBs.

A finding worth noting for its clinical implications is the observation of Ayer *et al.*⁴ that approximately 40% of the preadolescent children with SITBs (ie, the group with low levels of psychiatric problems) were largely comparable to children without SITBs in terms of their psychiatric profile. This finding reflects current challenges in assessing SITBs in this age group. As mentioned by the authors, it indicates that screening only children presenting with clinically elevated psychiatric symptoms and behaviors for SITBs may risk

missing a very high proportion of children with these outcomes. SITBs are determined by multiple factors, and there are likely important factors outside psychopathology (eg, child maltreatment³) that relate to these outcomes. Therefore, clinicians may benefit from applying universal screening not only in psychiatric populations but also in at-risk settings (eg, the emergency department⁸) and with other at-risk populations (eg, children with a history of maltreatment).

Finally, as correctly noted by Ayer *et al.*,⁴ there is currently a need for evidence-based measures of SITBs in preadolescents, and it is possible that the development of new instruments for assessing these outcomes may yield associations with different psychiatric symptom and behavioral profiles. If valid and precise assessment is a basic foundation of clinical care and research, the development of such measures, especially ones designed for use in clinical settings, is a necessary early step toward the ultimate goal of treating and preventing SITBs in preadolescent children. On this point, there may be reason for hope, as the National Institute of Mental Health recently has been investing in several efforts toward this end (eg,⁹).

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Dr. Liu is with Massachusetts General Hospital, Boston, Massachusetts; Harvard Medical School, Boston, Massachusetts; and the Stanley Center for Psychiatric Research, Broad Institute of MIT and Harvard, Cambridge, Massachusetts.

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Correspondence to Richard T. Liu, PhD, Massachusetts General Hospital, 55 Fruit Street, Boston, MA 02114; e-mail: rtiupsych@gmail.com

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