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Research Article

Children Suicidal Death Cases

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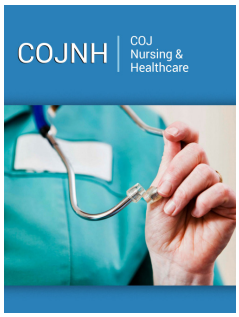

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Abstract

Background: The adolescents' suicidal attempts are serious public health concern. It causes psychiatric, economic and physical problems. The incidence of suicides increases rapidly until the age of 18 years. Suicide accounts for 1.5% of all deaths worldwide, making it the 10th cause of death. It is the third leading cause of death among children and adolescents aged 10 to 18 years.

Materials and Methods: We have examined 204 death cases of suicidal origin in 2018 who were autopsied by us to evaluate age, gender, suicide method, suicidal environment, distribution according to months and days, a diagnosed psychiatric disease and the presence of a previous suicide attempt. SPSS (Statistical Package for Social Sciences) for Windows 25.0 program was used for the statistical analysis of study data.

Results: In the results of the examination of 204 death cases of suicidal origin in 2018 are 20 cases (9.8 %) were underage of 18. 15 cases (75%) were male, five cases (25%) were female. 20 cases (9.8%) were underage of 18. The youngest age was 12 of all suicide victims. Hanging was the most commonly used method of suicide with seven cases (35%), followed by jumping from height (30%), firearms (20%) and self-poisoning (15%). 80% of the suicide cases occurred in domestic places.

Conclusion: The literature highlights the noticeable existence of childhood suicides, often unknown in the studied age range, and that it is possible to prevent suicide in childhood. Therefore, recognizing psychic distress and suicidal behavior in childhood is extremely necessary for these children to have adequate psychiatric treatment.

Keywords: Suicide; Suicide attempt; Suicidal ideation; Childhood deaths

Introduction

Adolescence is a developmentally important age stage due to the increased risk of suicide and the prevalence of psychiatric disorders, as well as increased prevention and treatment possibilities. And now adolescent suicide attempts are a serious public health problem. It causes psychiatric, economic and physical problems [1].The incidence of suicides increases rapidly until the age of 18. Suicide is currently the third leading cause of death for teenagers between the ages of 15 and 24, and approximately 4,600 young people between the ages of 10 and 24 commit suicide each year. Suicide accounts for 1.5% of all deaths in the world, making it the 10th cause of death. It is the third leading cause of death among children and adolescents aged 10-18 year [2].

While there are no specific tests that can identify a suicidal person, there are certain risk factors [3]:

A. Fixed risk factors include family history of suicide or attempted suicide, male gender, parental mental health problems, gay or bisexual orientation, a history of physical or sexual abuse, and a previous suicide attempt.

B. Social and environmental risk factors include the presence of firearms at home, deterioration of parent-child relationship, living outside the home (homeless or in a

correctional facility or group home), difficulties at school, neither work nor school, social isolation. The presence of stressful life events such as legal or romantic difficulties or an argument with a parent.

C. Psychiatric disorders in young adults significantly increase the risk of suicide. These people are very affected by relationship problems. Personal mental health problems that are susceptible to suicide include depression, bipolar disorder, substance abuse or addiction, psychosis, post-traumatic stress disorder, panic attacks and aggression, impulsivity, or a history of severe anger.

D. Among the biological factors found to be associated with suicidal behavior among young people are gender, ethnicity and sexual orientation. While female adolescents report higher rates of depression, anxiety, suicidal thoughts, thoughts and suicide attempts, males are four times more likely to die from suicide.

E. One explanation for this contradiction is that men tend to use more lethal methods (such as firearms) to commit suicide, while women choose methods that are more susceptible to medical interventions (such as overdose or poisoning).

Having a stressful life often precedes suicide attempts for adolescents. Although it is not the cause of suicide, these events can make the adolescent feel more vulnerable and cause a feeling of hopelessness and helplessness. It can cause the individual to become overwhelmed or impulsive [4]. Relationship breakups, parental divorce, death of a loved one, military duty of a parent, academic failure, and physical/sexual child abuse are events that usually occur before the suicide attempt [1,4].

Mental health problems and psychiatric disorders are reported to be an important risk factor for suicidal behavior in adolescents. Such psychiatric disorders can put teens at an increased risk of suicide, or any combination of these disorders can significantly increase the risk of suicide. Depression is the most common disorder associated with adolescent suicidal and suicidal behaviors and often coexists with other diagnosed disorders [4,5].

Depressive symptoms and examples that can be seen in adolescents are [6]:

a) Suicidal ideation: The point prevalence of suicidal ideation in adolescence is approximately 15-25%, and its severity ranges from death and passive thoughts to deliberate or planned private suicidal thoughts.

b) Suicide attempt: Lifetime estimates of suicide attempt among adolescents vary between 1.3-3.8% for men and 1.5-10.1% for women.

c) Repetition of suicidal behavior: Suicidal behavior tends to recur and may be a harbinger of suicide completion. Estimates of the risk of recurrence of suicidal behavior range from 10% at 6-month follow-up to 42% at 21-month follow-up with a median recurrence rate of 5-15% per year.

Materials and Methods

In this preliminary study, we aimed that to reveal the sociodemographic characteristics and forensic medical significance of suicidal child death cases. The cases referred to us by the prosecutor's office and thought to be the cause of suicide as a result of judicial investigation were evaluated. We have examined 204 death cases of suicidal origin in 2018 who were autopsied by us to evaluate age, gender, suicide method, suicidal environment, distribution according to months and days, a diagnosed psychiatric disease and the presence of a previous suicide attempt. Post-mortem examination and autopsy records of cases who died in consequence of suicide were studied.

Results

There were 204 suicide cases autopsied in 2018. 20 (9.8%) of all cases were underage of 18. The youngest age was 12 of all suicide victims. Fifteen of those (75%) were male and five (25%) were female. The preponderance of male cases in our study was also detected in suicidal hanging cases. Hanging was the most common used method of suicide with seven cases (35%), followed by jumping from height (30%), firearms (20%) and self-poisoning (15%). Table 1 shows the suicide rates and numbers by methods. In 16 (80%) cases, the place of suicide was the domestic places. Others preferred anywhere except home like schoolyard, field and public places. Table 2 shows where, rates and numbers suicides occurred. When the suicide times were evaluated by months, it was seen that the most frequent cases were in September. September was the month with the highest suicide rate with four cases (20%). And we got a rate that started in May and increased to summer. Suicide rates and numbers according to the seasons are shown in Table 3. When the rates and numbers of suicide are examined according to the days of the week, Thursday was the day with the highest suicide rate with five cases (25%). When the suicide attempts and psychiatric treatments of the cases were examined in our study; Three cases (15%) had received psychiatric treatment before, two cases (10%) had attempted suicide before.

Table 1: Suicide rate by methods.

Method of Suicide	%*	n*
Hanging	35	7
Jumping From Height	30	6
Firearms	20	4
Self-Poisoning	15	3
Total	**100**	**20**

Table 2: Suicide rate by location.

Places	%*	n*
Domestic Places	80	16
School Yard	5	1
Field	10	2
Others	5	1
Total	**100**	**20**

Table 3: Suicide rate by seasons.

Season	%*	n*
Spring	15	3
Summer	45	9
Autumn	30	6
Winter	10	2
Total	**100**	**20**

*September was the month with the highest suicide rate with four cases (20%).

Discussion

20 cases (9.8%) were underage of 18. The youngest age was 12 of all suicide victims. Suicide rates consistently increase from childhood to adolescence, perhaps because of the greater prevalence of psychopathology in adolescents, particular combinations of mood disorder and substance abuse, and the greater risk for suicide conveyed by psychopathology in older adolescents. Adolescents are also more cognitively capable of planning and executing a lethal suicide attempt and show greater planning and intent than younger suicide victims [7]. 15 cases (75%) were male; five cases (25%) were female. We all know that, although female adolescents report higher rates of depression, anxiety, suicidal thoughts, ideations, and suicide attempts, males are four times more likely to die because of suicide. One explanation for this contradiction is that males tend to use more lethal means to commit suicide (such as firearms), whereas females choose methods that are more responsive to medical interventions (such as drug overdose or poisoning) [8].

Hanging was the most commonly used method of suicide with seven cases (35%), followed by jumping from height (30%), firearms (20%) and self-poisoning (15%). Among the methods of suicide that resulted in death, hanging is most common. Adult victims preferred secondly firearms as a suicidal method, but child victims preferred secondly jumping form height. The possible reason for this is the difficulty of finding firearms with children. 80% of the suicide cases occurred in domestic places. Others preferred anywhere except home like schoolyards, fields and public places. The report on "Preference of the place of death" is very interesting. Kulkarni et al. "Most of the people surveyed by us prefer to die at home where they are relatively comfortable," he said. "Home" is also the most preferred place of death, according to a recent report from China. They also stated that "patients living in rural areas, with a low level of education and living with their relatives, prefer to die at home more [9].

September was the month with the highest suicide rate with four cases (20%). And we got a rate that started in May and increased to summer. As noted in a study conducted by Timo Partonen and colleagues, "There was a seasonal effect on suicide occurrence among the study population in Finland and the risk of suicide was highest in May during the study period and the lowest in February" [10]. Similar results were reported in the article by Lester and Franks titled "Sex differences in the seasonal distribution of suicides". An international study of seasonal effects on suicide rates spanning 20 countries showed that suicides peaked in early summer. He concluded that "the seasonal variation in the incidence of suicide can be explained by the increase in sunlight during the summer months due to the relationship between sunlight, high temperatures and suicide rate". French sociologist Émile Durkheim found similar results and reported more suicides. Instead of emphasizing the role of nature, Durkheim interpreted the seasonal differences in sociological terms, that most suicides occur in the spring, because "everything starts to awaken; activity begins again, relationships rise, exchanges increase. In other words, the environment that causes higher suicide cases in spring or summer. it is not the density of human interactions" [11-13].

Behavioral psychologist Friedrich V. Wenz evaluated the seasonal effects on suicide rates and investigated the relationship between seasonal effects and psychopathology. Wenz's experimental literature states that suicide attempts resulting from loneliness are highest in spring and summer, and lowest in winter [14]. Our study is compatible with literature because it shows increasing suicide rates in the summer. The increase data in September can be explained by the narrow sample size. Studies show that the highest season of suicide cases is spring, and the lowest season is winter. However, Fotis Papadopoulos, a professor of psychiatry from the University of Uppsala in Sweden, says that if we base our winter suicide rates, the suicide rates in the spring are between 20-60% higher. As a result of examining the forensic and meteorological records of 12,000 suicide cases in total, it was shown that there was a relationship between monthly sunlight duration and suicide risk for only a small group [15].

Thursday was the day with the highest suicide rate with five cases (25%). According to a study called ``Suicidal Tendencies in the United States in the 20th Century,'' the week-long distribution of suicides reveals that the number of suicides was highest on Monday and lowest on Saturday for both men and women. Research published in Social Psychiatry and Psychiatric Epidemiology found that people are much more likely to kill themselves at the beginning or end of the week than at the beginning or the end: almost 25 percent of suicides occur on Wednesdays, compared to 14 percent on Mondays. Or a two-day draw for the second highest suicide rates on Saturdays. The study also found that if you continue until Wednesday, your risk of suicide is reduced by more than half the next day; It has the lowest suicide rate, with just 11 percent, on Thursdays. In our study, we found that three cases (15%) had received psychiatric treatment before. In a study published in the journal Social Psychiatry and Psychiatric Epidemiology in 2014 with 2429 cases showed that, compared with people who had not received any psychiatric treatment in the preceding year, the adjusted rate ratio for suicide was 5.8 for people receiving only psychiatric medication, 8.2 for people with at most psychiatric outpatient contact, and 44.3 for people who had been admitted to a psychiatric hospital [16].

Two cases (10%) had previously attempted suicide. A recent analysis of studies that examined successful suicides among those who made prior attempts found that one person in 25 had a fatal repeat attempt within five years. A study at the Mayo Clinic followed the first suicide attempts that occurred between January

1986 and December 2007 in a county in Minnesota and recorded all deaths from suicide for up to 25 years after that. It was found that 5.4% (n: 81) of 1,490 people who attempted suicide died as a result of suicide, 48 of them died at the first attempt. The findings are reported in the American Journal of Psychiatry. Counting all who managed to kill themselves, including those who died on their first attempt, the death rate among those who attempted suicide was approximately 59% higher than previously reported. According to these data; average of 2 thousand 963 people in Turkey every year, 246 people committed suicide every month. Of those who died as a result of suicide in 2018, 2391 were men and 770 were women. In other words, the rate is 75.64% for men and 24.36% for women [17].

European Statistics Agency (Eurostat) report released by the suicide rate in Europe, according to Turkey, has the lowest suicide rate in Europe. Eurostat people committed suicide in 1856 in Turkey according to 2016 data, but it has 3161 people commit suicide according to the Statistics Institute of Turkey. Therefore, we believe that the statistics were not good [18]. According to a study conducted by Pamukkale University Faculty of Medicine; Medical records of patients under 18 who attempted suicide between January 2009 and December 2011 were reviewed by a child and adolescent psychiatrist. Of the 61 patients who attempted suicide, 45 (73.8%) were female, 48 (78.7%) were between the ages of 15-17. Medication overdose was the most common way of attempting suicide (83.6%). 65.6% of these patients were diagnosed with psychopathology. The most common psychiatric disorders are major depressive disorder, behavioral disorder, and attention deficit hyperactivity disorder. Conflicts with family and boyfriend/girlfriend relationships were the most common trigger of suicide attempt [19].

According to a research, Patients who applied to Erciyes University Pediatric Emergency Service between January and December 2017 due to suicide attempt were evaluated retrospectively. Of the 50 suicide attempts, 42 (84%) were girls and 27 (54%) were between the ages of 14-16. Medication overdose was the most common way of attempting suicide (100%). The most common psychiatric disorders are generalized anxiety disorder, major depressive disorder, behavioral disorder, and obsessive-compulsive disorder. Family problems were the most common triggering factor for suicide. It was determined that 8% of the cases still wish to die [20].

Tel et al. [21] state that patients admitted to the emergency department with suicide attempts are intensive between the ages of 15-19. In our country, suicides show intensity between the ages of 15-24 and 25-34. In terms of suicide rates, there is a faster rise in youth than all age groups. A study conducted in our country reports that 59% of suicide cases admitted to the emergency department are in the 16-24 age group, in accordance with the literature [21]. Another study conducted in our country; it states that suicide cases admitted to the emergency department are concentrated between the ages of 15-34 (81.3%) [22]. In the study carried out by Aktepe et al in our country and the children-adolescents who committed suicide examined socio-demographically-psychiatrically; It is reported that a significant part of the cases (89.7%) are girls and adolescents, while the 15-16 age group is the most risky group [23]. However, in another study in which suicide cases admitted to the emergency department were investigated from a socio-demographic perspective, the age range of suicide cases admitted to the emergency room varies between 25-34 [24].

Like most countries of the world, Turkey also known as male completed suicide rates were higher than female suicide rates. On the other hand, it has been observed that female suicide rates are higher than male suicide rates in some districts of Southeastern Anatolia Region. 54% of those who committed suicide or attempted suicide were female and 46% were male in a study in which suicide cases under the age of 18 who were admitted to the emergency department were examined socio-demographically. Some important findings of the study show that almost half of all female suicides occur between the ages of 15-20 and in rural areas of the city. Being single and young, living with family, illiteracy, being a housewife/girl, and social isolation are risk factors for suicidal behavior. According to a study, patients who presented to the emergency department of Batman State Hospital between June 1, 2012 and June 1, 2017 were evaluated retrospectively. In this study, it was found that suicide and suicide attempts were higher in married women aged 15-24 years with 57.1% (n:512). The young female population is forced into suicide by being forced to marry old men at a young age, with a low educational level, domestic violence and oppressive behavior towards these women. We believe that necessary measures have been taken in order to be effective in reducing suicide and suicide attempts by the authorized institutions. As a result of all the studies, a community-based suicide prevention model is needed in the context of violence against children [25,26].

When the average suicide attempts is examined by education level in our country, it is determined that the rate of suicide increases as the education level decreases. In a study, 98.9% of those who attempted suicide declared their religious belief as Islam, while 1.1% did not believe in any religion. This may be because people living in our country mostly believe in the same religion. A large part of the people in Turkey with Islamic beliefs. In addition, it should be said that suicide is forbidden according to Islamic belief, so the place of death can be changed by the families of the victims, the actual cause of death is hidden, and the clinicians are tried to be deceived. in emergency services. And unfortunately, with the suicide cases that went to the emergency; There are insufficient data to identify religion as a risk factor. However, according to many people, religion is one of the factors that deter people from suicide in Turkey [7]. "Fear of God, eternal hell anxiety, a serious justification for giving up suicide in our country."

Suicide can be seen in all segments of society, from people with severe mental disorders to ordinary people who react to stressful life events such as migration. It has been found in the literature that immigrants have more suicidal attempts and thoughts than

the local population. According to the latest statistical data, the number of immigrants is increasing all over the world. And this increase brings about housing, nutrition, health and education problems. Children are one of the groups most affected by these problems. Mental health problems such as anxiety, post-traumatic stress disorder, somatic symptoms, depression and suicide stand out among immigrant children. As of 2017, there is an increase in suicide reports for immigrant children. This shows that immigrant children are a risky group in terms of suicidal thoughts and behaviors [27].

There are more than 1.6 million immigrant children in our country as of 2018. These children who escaped from war are in the risk group due to the traumas they experienced and the negativities they experienced during the adaptation process. According to the 2018 study of Çeri, 31.7 % of the children who applied to the "Immigrant Child and Outpatient Treatment Unit" had anxiety, 31.7 % attention deficit/hyperactivity disorder, 24.4 % major depressive disorder and 22 % was diagnosed with post-traumatic stress disorder. In Topçuoğlu's study, it has been revealed that immigrant children face risks such as "social and cultural incompatibility, inability to speak the language, not being able to benefit from social benefits, poverty, psychological problems". In a study of Uğurlu et al. with 63 Syrian immigrant children, 23.40 % of the participants had high levels of post-traumatic stress disorder, 17.60 % had severe depression symptoms, 14.40 % had severe state anxiety and 31.10 % had severe trait anxiety symptoms [28-30].

Conclusion

Once someone attempts suicide, the risk of attempting suicide again may increase, so society and state's perspective and approach to suicide cases should be changed. There are effective techniques for lowering suicide rates [31]. The most important thing to do in this regard is to restricting access to the means of suicide (firearms, chemicals etc.) [32]. The media should avoid suicide contagion by avoiding front-page coverage, sensationalizing suicide, and can assist by providing information on treatment resources. Suicide screening at schools can identify adolescents who have mental health problems. Because the accurate diagnosis of psychiatric disorders and their successful treatment can significantly reduce suicide rates. Treatment of psychiatric patients should be financially/morally supported, health professionals should be trained on the subject, maximum sensitivity should be shown during the rehabilitation process and patients should be returned to the community as healthy individuals [33,34]. Suicide screening in schools can identify adolescents with mental health problems. Because the correct diagnosis and successful treatment of psychiatric disorders can significantly reduce suicide rates. As only rarely young suicide victims receive psychiatric care, broad prevention strategies are needed in health and social services. To prevent suicides, it is recommended that physicians be trained to recognize young people at risk and their access to lethal tools is restricted. It is important to ensure continuity of care for high-risk youth.

Recognition and effective treatment of psychiatric disorders, eg. Depression is essential in preventing adolescent suicides. As only rarely young suicide victims receive psychiatric care, broad prevention strategies are needed in health and social services. To prevent suicides, it is recommended that physicians be trained to recognize young people at risk and their access to lethal tools is restricted. It is important to ensure continuity of care for high-risk youth. Recent treatment studies among suicidal adolescents have reported promising results in safety planning and increased therapeutic exposure early in treatment. The treatment of psychiatric patients should be supported financially/morally, health professionals should be educated on this issue, maximum sensitivity should be shown in the rehabilitation process, and patients should be returned to the society as healthy individuals [24,35,36]. There are relevant institutions in our city so that people with addictive drug addiction can be brought into society. Adana Ekrem Tok Mental Health and Diseases Hospital provides service with 80 beds for addicts and 10 beds as a separate area for female addicts. In addition, the studies of the Child and Adolescent Substance Addiction Treatment Center (ÇEMATEM), which is designed for children only, will serve with 15 beds. Adana City Hospital site, carrying the first of its kind in Turkey High Security Forensic Psychiatry (YGAP) in the hospital, being treated for convicts with a capacity of 100 beds [28,37].

The literature highlights the noticeable existence of childhood suicides, often unknown in the studied age range, and that it is possible to prevent suicide in childhood. Therefore, recognizing psychic distress and suicidal behavior in childhood is extremely necessary for these children to have adequate psychiatric treatment [21,22]. Protocols should be developed for the early recognition of suicidal behavior. Health professionals and teachers should be empowered to be able to help children with suicide risk predisposing signs. The impression of young adolescent suicide is a disadvantaged, vulnerable and distressed group that grows in extremely difficult conditions. There is clearly a need to verify these impressions with an in-depth investigation of the familial and social circumstances of children who die by suicide. Such investigations might best be conducted by annual mortality review and monitoring of all young adolescent suicides. Policies and laws of the relevant sectors (e.g. education, employment, disability, judicial system, human rights protection, social protection, poverty reduction and development) are important tools to meet the multi-dimensional needs of a suicide prevention strategy and ensure sustainability.

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