5th Joint Meeting on Adolescence Medicine

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Aula Consiliare e Sala dei Concerti, Palazzo de Nobili, Catanzaro (Italy)

THE "QUITE LOST" ADOLESCENT AND A&E (THE SUICIDE ATTEMPT)

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ADOLESCENCE

CHILDHOOD ➡ **ADULTHOOD**

- Ideals
- Anxiety

Appearance

- Physical
- Cognitive
- Social

ADOLESCENCE

- Puberty → Physical development
- Adolescence → Growth and psycological development

… both important in the assessment and care of young .

It' s important to understand

- Mechanisms
- Deviances
- Pathogenicity

PRE-ADOLESCENCE

(from six years old)

Transition

- Concrete operational thinking
- Formal or abstract logical thinking

…due to the interaction beetwen physiological neuronal maturation and cerebral in-put from new experiences of outside world

Preadolescents may be able to

Apply

formal logical thinking → **to study, <u>but not to personal fixes</u>.**

When emotional stakes are high, it's possible that an adolescent <u>regresses</u> to a more concret, operative and/or magical type of thought.

PRE-ADOLESCENCE

(from six years old)

- Weight the consequences of decision
- Understand the priorities
- Create strategies
- Ability to inhibit the pulses

PRE-ADOLESCENCE

(from six years old)

More intense emotions → Looking for extreme experiences

Development of moral thinking → Reward, right and motivated punishments

PRE-ADOLESCENCE

(from six years old)

"I grow" so "I exist "

Internet or TV
(more than 3 hours a day)

Distorted perception of reality and values

Changes of beahavior depressive disorders

"STEREOTYPICAL" ADOLESCENCE

(Females – approximately from 11 to 16 years old
Males – approximately from 13 to 18 years old)

Parents → peers
boyfriends or girlfriends
friends

"storm and stress"
STURM UND DRANG!!!
(20-30% of young)

"STEREOTYPICAL" ADOLESCENCE

(Females – approximately from 11 to 16 years old
Males – approximately from 13 to 18 years old)

can develop confidence and appropriate social skills → Establish satisfactory relationship

Explore future options → Self-assesment

↓

Exploring available opportunities

Importance of presence or absence of realistic role models, compared to previous idealized periods !

LATE ADOLESCENCE

(Approximately between 18 and 25 years old)

- Research of social and economic stability
- Development values
- Looking for a partner

Where does the problem come?

Economic family dipendence

Regret for choice not conform to own attitudes

LATE ADOLESCENCE

(Approximately between 18 and 25 years old)

IDEALISM → **Absolutism**

↓

Intolerance of opposing views
(adherence to exstreme political and religiouos groups)

↓

difficulties in communication

In any time, during these difficult period of transition, a dramatic event, if not well managed, can result in attempted suicide

EPIDEMIOLOGY

In the world: about 4 million of attempted suicide among adolescents/year, resulting in about 100000 death/year.

OMS 2007 estimates: Suicide = about 3% of causes of death in the world.

In absolute estimates the most part of suicides in China e India (30% of total cases)

OMS 2000 estimates: the highest rates of suicide are in Eastern Europe and Asian Countries like China e Japan.

Age < di 15 years old = 2% of all cases of suicides. First cause of death in China, Sweden, Ireland, Australia e New Zealand.

Age: 15-24 years old. First cause of death in numerous contries.

Age: 25-55 years old. First cause of death in all countries in the world, higher than - in absolute numbers – total deaths due to war and murders.

According to the Observation of the Behaviour Young Center in 2001 the 2,6% of American students had **attempted suicide** and had to seek medical care.

Main predictor risk factor

EPIDEMIOLOGY

- Peak at the beginning of twenty years old .
- USA: about 2000 teenager suicides/year

- Puberty: males/females ratio= 3/1
- Late adolescence: males/females ratio= 4,5/1
- Increase in black population> white population.

In Italy there are between 3.500 and 4.000 suicides/year.

In 2004 the "official" suicides were 3.265 according to ISTAT (758 women and 2.507 men), with rate = 5,6/100.000

(North East >> South).

Highest rate = Friuli Venezia Giulia = 9,8%

Lowest rate = Campania = 2,6%

2004:

Prevalence age < 18 anni < 1%

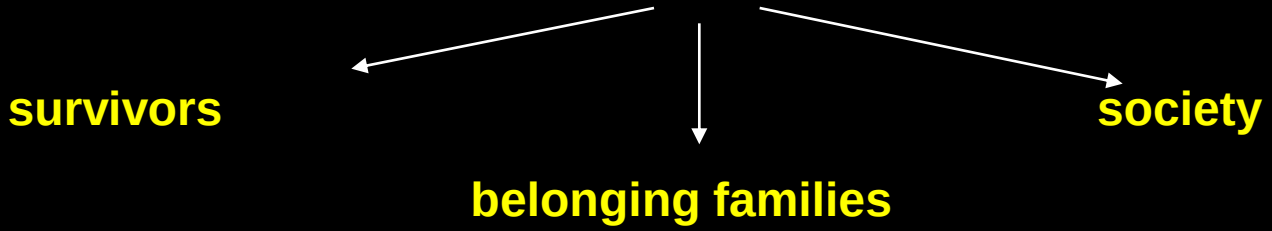
Prevalence from 18 to 64 years old ≤ 2/3

Prevalence age > 65 anni ≥ 1/3

UNDERREPORTING

About seven attempted suicides for each suicide

Psycological trauma



Survivors shame, reassuring reasons,
negligence in drawing up reports
“sudden deaths” or “deaths for unknown causes ”
deaths after days “due to” attempted suicides
unexplained road accidents
suicidal events in prison
addicts voluntary overdose.

CAUSES: Biopsychosocial description

OMS: variability for continents and different countries (culture, society, economy)

Mental disorders: > 90% of suicides (depression, schizophrenia and personality disorders, anxiety, impulsivity and low self-esteem too)

Genetic factors: ideation and suicide attempts common in monozygotics more than dizygotics; inherited abnormalities serotonin system > P completed suicide.

Environmental factors falling: relationship and familiar problems, physical and psycological violences suffered, bereavements, divorces e separations, alcohol or drug dipendencies, in family too (the 5-10% of addicts commits suicide), physical chronic and painful disorders (cancer and HIV in primis), neurological disorders, other traumatical recent events , loneliness.

Other causes :

Adolescents identifing themselves as omosexual have increased risk of suicide; those affected by disphorya of gender seem to have higher risk.

For some recent immigrants suicidal ideation is associated to high levels of cultured stress, in particolar for familiar dysfunction and limited possibility choice.

Feeling of hopelessness associated to a current psycological state.

Adolescence, a delicate period of "transition", makes more complicated the problems also in Emergency !

In addiction to diseases that typically onset or have a higher incidence of complication in this age,
we must also deal with all the problems we have seen therefore related to mental and behavior state in adolescents.

Especially in last decades, in which the society has undergone radical changes, child psychiatrists are increasingly involved in psychiatric emergencies, also in pediatric age !

However, it is not always possibile to give early and accurate diagnosys. This is due both to limited available means, and to lack of specialized staff.

This often causes delay or failure to "intercept" children and adolescents at risk!

States of familiar hardship or child mental disorders are often hidden to the doctor.

Besides, self-injury is often not reported by patient, it is not recognized by doctors and nurses and so it does not lead to health medical care.

PAY ATTENTION!

Emergency must pay attention to injury, disease or events of unclear origin.

Pay also attention to anamnestic/behavioral omissions or contradictions !

Attempted suicide term is used in a wrong way!

Deliberate self-harm: ***self-injurious actions, performed without the purpose of death***

Suicidal ideation: ***it is caracterized of several severity stage according to specific suicide plans and proportion of suicidal purpose***

Suicide threat: ***verbalizzation of suicidal purpose, or starting an action that, if completed, lead to suicide***

Suicidal gesture: ***suicidal threat accompanied by a suicidal gesture (considered by patient) of low lethality***

Parasuicide: ***behavior missing real death purpose, but communicating anyway suicidal purpose***

Suicide attempt: ***real attempt to commit suicide, not c ompleted for reasons beyond the suicide control. Evaluate the lethality action***

In the last five decades the incidence has drammatically increased in younger age groups!

Suicidal behaviour and self-destructive actions represent 50% of emergency accesses in children and young adults!

Risk factors

- Previous suicide attempts
- Combination with alcoholism, drugs or risk behaviour
- Previous familiar suicidal cases
- Psycopathologies in parents
- Feelings of depression and despair
- Noise in the image of himself, anxiety crisi/panic attack
- Tendency to impulsivity or aggression
- Easy access to letal means such as weapons
- Sexual or psychological abuse history
- Omosexual tendency (tendency to suicide, even if not completed)
- Difficult relationship between parents and children
- Life stress, in particolar sudden loss of interpersonal relationship , legal or disciplinary problems
- Missing involvement at school or work
- Missing protective factors

Warning lights

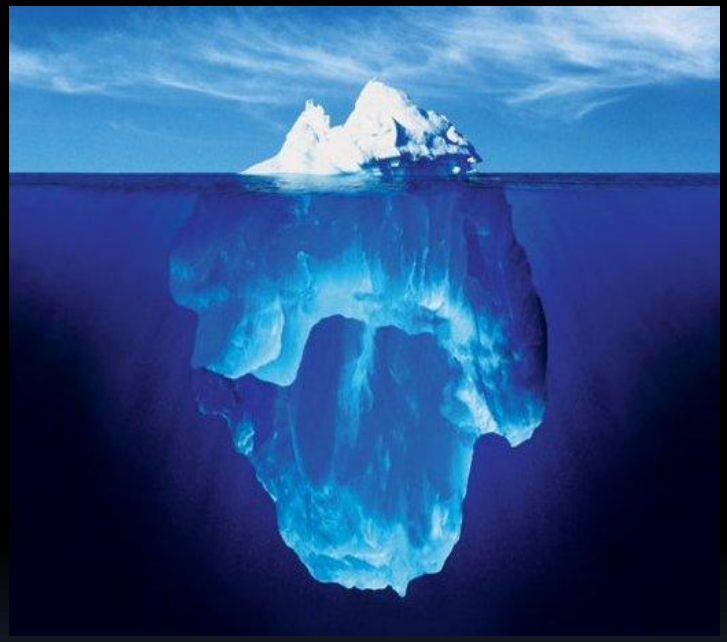
- Change in eating habits or sleep patterns
- Departure from friends, family and regular activities
- Violent and dangerous actions, rebellion behaviours, tendency to avoid
- Alcohol and drug abuse
- Poor self-care
- Significant change in personality
- Persistent boredom state, concentration difficulty, decreased performance at school or work
- Repeated complaints of disorders, like abdominal pain, headache, effort ecc., often related to emotions
- Loss of interest in leisure activities
- Intolerance towards praise or avowals

PROTECTING FACTORS

Resilience: individual ability to overcome negative e traumatic events thanks to an adaptament, and to resist with success to adverse situations, by learning to develop competences from difficulties and by enforcing the self confidence.

It's an individual response to crisis situations, but today it's also considered as the response of larger social sistems like school, family, organizations and society, which must promote its process development.

THE ATTEMPTED SUICIDE PROBLEM IS ONLY THE TOP OF AN ICEBERG!



Does the “modern” civilian society offer more resilience processes or more risk circumstances?

It's necessary to individuate quickly

- PSYCHIC VULNERABILITY MANIFESTATIONS

→ attention to the patient and to his behaviors!

- VULNERABILITY CONTESTS

→ attention to his environment and to the events of his life!

IN A&E WE CANNOT ONLY THINK ABOUT HARMS AND INJURIES OF AUTOLESIVE BEHAVIOUR.

JUST STEADIED,
WE MUST ABLE TO "PICK UP"
THE ADOLESCENT AND HIS FAMILY AND
TO PUT THEM IN A SPECIFIC PATH

INTERVENTION STRATEGIES

→Management

→Monitoring

→Prevention

What are the characters who can at first take part to identify subjects at risk and so to the prevention?

MEDICAL DOCTOR

FAMILY

PEDIATRICIAN

Facilitate the family dialogue

Even in the consulting room

Separate interviews

children

parents

informed adult who doesn't judge

Questions on his relationships with family and friends

- continuum of development
- personalized counseling
- Eventually asking for mental health professional doctors

AAA: think about eventual omosexuality

PEDIATRICIAN

Separate interviews

children

parents

help them to distinguish among a normal age-linked discomfort and really dangerous behaviour

Normality:

- try to have more autonomy

Abnormality:

ritiro o antagonismo estremi

- confusion and disphory at the beginning of the first two years of superior classes
- propension to the assumption of risk during pre-adolescence

persistance and escalation for several weeks or months

So, we can ask to ourselves:

-How do we face psychiatric emergency in evolutive age?

-Are we just ready to receive these guys and to support their family?

-Do we know offer a correct environment to the adolescent who has attempted the suicide or who is confused about himself and so who's looking for help?

-What kind of management can we offer to them, today, in our hospital structures?

2008, USA: *"Opportunity to promote the Risearch on Children Neurological and Psychiatric Emergency"*

(Ann Emerg Med., D'Onofrio G et all., nov. 2010), members of a Task Force (espertizes of urgency medicine, neurology and psychiatry) and academical leaders of NIH (National Institutes of Health)

(1) need to create an infrastructure for the identification of urgency

(2) need to innovate strategies and diriment diagnostic instruments for decisional process (biological detections, evaluation of symptoms and application of therapy)

(3) Creation of a network of collaboration among the different structures, to assure the best health assistance

(4) organisation of staff training programs for practice in urgency medicine

Centre Hospitalier Universitaire de Bicêtre (Francia)

first emergency unit of psychiatry for children

-phone-lines to attend directly affected subjects and to support their families;
-medical consultations and social instructive addresses;
-consults to evaluate the psycopatological/psychiatric discomfort;
-psychiatric A&E 24h / 24;
-sleep places for treatments of short periods (1-3 weeks);
-strict collaboration with every department ofevolutive age of all national hospitals

And in Italy?

We have to think:

-What does it happens in our Country?

-Does it exist a supporting network for the adolescent who loses its sanity?

-Does it exist a project to realise specifical structures and networks for the management of these adolescents?

Actual propositions to infant psychiatrists: realization of *help-lines* wich can be heasily accessible to boys and girls with psychic discomfort

Worthy existing realities,
but great discrepancy among regions

Suicide is not only a problem of the individual subject.
Its social damage is enormous, estimated in billion of dollars and it corresponds to the economical potential
of lost lives,
to medical and psycological treatments of suicide attempts,
to the affliction of relatives and friends of the victim.
Every suicide hits in a harrying way on average other six persons

According to recent studies

people with suicidal ideations

often speak about suicide, death and or about the lack of motivs to live

and give specific admonitions on their own suicidal intentions

People who attend this "silent cry" could not understand or could not know how to respond

No more "Run toward death"

Escape

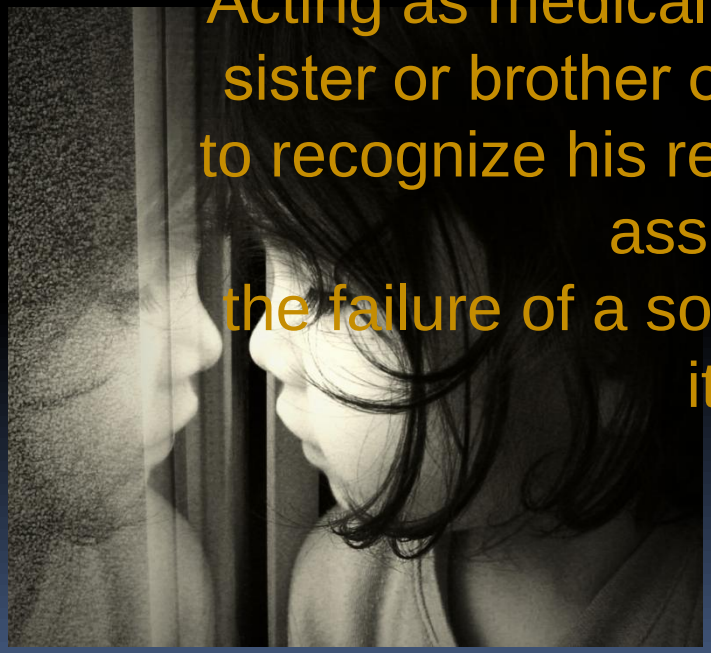
from an intolerable emotion, or an unendurable, unacceptable anguish

If the level of suffering would be reduced the individual would choose to live!

To detect affliction causes so becomes essential, as like as to solve the problem that has created it

Everybody may come in the situation to lend a helping hand to a “quite lost” adolescent.

Acting as medical doctor, tutor, father or mother, sister or brother or friend, if we don’t undertake to recognize his request for help, we could again assist to our failure:
the failure of a society unable to preserve even its own future.



Grazie per l’attenzione