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Identifying suicide risk factors in children is essential to developing effective prevention interventions

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Suicide is a leading cause of death among children and adolescents, yet there is a dearth of high quality, large-scale research focused on children. This is a concern in light of the robust evidence that rates of suicidal ideation and suicide attempts in this age group have increased markedly in recent years¹. This study by Delfina Janiri and colleagues² in *The Lancet Psychiatry* of almost 8,000 children is therefore particularly welcome. Indeed, given that 8 out of every 100 children in their sample reported some aspect of suicidality (most commonly suicidal ideation), family members, teachers, and clinicians need to be vigilant.

This study has many strengths: it reports on a large and nationally representative sample of 9-10 year olds; it includes independent child and caregiver reports of wellbeing and suicidal history; and it incorporates a diverse range of measures assessing personal, family and social characteristics. To our knowledge, this is the largest and most detailed population-based study of suicidality (i.e., suicidal ideation, suicidal plans and suicide attempts) yet conducted in this age group. For the most part, Janiri et al.'s findings complement existing evidence from adolescent and older age groups, by highlighting the role of child psychopathology and child-reported family conflict in the emergence of suicidality. If we are to develop effective suicide prevention interventions, it is essential we identify and target these childhood risks. In particular, greater effort to protect children from early life adverse experiences is vital given that family conflict was associated with between 30 and 75% increased risk of experiencing suicidality beyond the effect of psychopathology.

The findings related to suicidality and screen-use are novel. Janiri et al. found that higher weekend screen utilization time was associated with an increased risk in child-reported suicidality and this relationship appears to be stronger in boys than in girls. This is a potentially interesting insight but the nature of the relationship needs to be teased out and the direction of the relationship requires clarification. Similar to a recent study of adolescent wellbeing³, the association between digital technology use and suicide risk is likely to be small, and it is not clear from the present analyses whether the relationship holds over time. Moreover, and as noted by the authors, future research is required to determine which factors account for the screen time–suicide risk relationship. As digital technology use confers benefits as well as risks, screen time use may be too blunt a measure to pinpoint the specific pernicious aspects associated with suicide risk. Negative social comparison processes⁴ and

cyberbullying⁵ have been implicated in suicide risk in adolescents and young adults and may offer two possible explanatory mechanisms within the screen time-suicide risk association.

The surprisingly poor child-caregiver concordance in the reporting of suicidality finding is a potentially important and noteworthy contribution to the methodological and clinical literatures. In short, if we wish to learn about a child's suicidality or to assess suicide risk, we need to ask the young person directly. In this age group, it seems caregiver report is an unreliable method of assessment. More widely, these findings may also warrant a review of the extant literature on childhood suicidality as the present findings would suggest that a reliance on caregiver reported suicidality may have under-estimated the prevalence of suicidal phenomena in children.

Too often, studies in the suicide prevention field have focused on risk factors and, as a result, it is often difficult to identify protective factors to target in psychosocial interventions. For this reason, it is rewarding that the focus here includes potential buffers, and it is valuable to see parental and positive school involvement emerge as robust factors associated with reduced suicide risk in children. In respect of the former, it would be useful to better characterise which components of parental involvement are most important in protecting against suicide risk. The latter finding, in particular, adds to the growing evidence that school-based interventions can reduce suicide risk⁶. Given the poor child-caregiver concordance in reporting suicidality, raising awareness in teachers of potential warning signs of suicidality in children may be appropriate, and an important component in the development of school-based interventions.

The findings make an important contribution to extending the existing literature on suicidality in younger children, however they are limited by being cross-sectional and by the small number of children who had formulated a suicide plan or attempted suicide. As a result, it was not possible to discern those factors which differentiated between suicidal thoughts and suicidal acts. This is unfortunate given the growing recognition that the factors associated with the emergence of suicidal thoughts are distinct from those which govern a suicide attempt^{7,8}. A key focus for future research, therefore, needs to be on the factors that facilitate as well as impede the transition from suicidal thoughts to acts of suicide. Finally, a more in-depth appreciation of the process of behavioural enaction will lay the foundations for the development of suicide prevention interventions targeted at childhood risks.

Declaration of interests

RCOC and KAR have no conflicts of interest

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