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Case Report

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A Case Report: Attempted Suicide and Suicidal Behavior in an 8 Years Old Child

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Summary

In most of the countries suicide is one of the ten leading causes of death and for young people it is the second most common cause. But in children suicide is rare and associated with severe personal and social problems. A useful definition of suicidal behavior in children developed by Pfeiffer is "Any self-destructive behavior that has intent to seriously damage oneself or cause death (1986)". The thought of a child dying by suicide challenges the ideals we hold about how our children grow and develop at their own home and society. It also raises considerations about children's understandings of death and their capacity to have the intent to suicide. The relationship between psychiatric disorders and adolescent suicide is now well established. Mood disorders, substance abuse, conduct disorder and prior suicide attempts are strongly related with youth and child suicides. Factors related to family adversity, style of parenting and child rearing, recent socio-cultural transition and other precipitating problems also contribute to the risk of suicide. The main target of effective prevention of child and youth suicide is to reduce suicide risk factors. Recognition and effective treatment of psychiatric disorders, e.g. depression, conduct disorder, oppositional defiant disorders are essential in preventing child and adolescent suicides. In the treatment of youth depression, psychosocial treatments have proved to be useful and efficacious. Here we have described about the case of a 08 year old boy, presenting with restlessness, impulsiveness, multiple threats and one episode of attempted suicide following refusal to watch TV by parents.

Introduction

There is an increasing trend of suicide in children and adolescent in recent years. Suicide now represents the third cause of death in children and adolescent. Completed suicide is commoner in males. However attempted suicide and deliberate self-harm is common in females1. There is a very strong association between suicidality, depression and conduct problems including substance misuse.

Case study

Master Kawser Haider, only son of lance corporal Dulal Hossain, 08 years old boy was brought to outpatient department of psychiatry by his parents with the complaints of (as stated by his parents and patient) excessive demand, frequent breaking of household materials, restlessness and impulsivity for last 04 years .Recently he attempted suicide by hanging on window of bed room on 21 August at about 2130 hrs.

History of present illness revealed that he started to show his excessive demand just after he started to speak` and walk properly at his own. He had a great attraction to colorful, moveable and harmful toys like knife, pistol and sword etc. If his parents resisted to fulfill his demand he becomes very much aggressive and violent & break household materials (TV, Mobile, mirror, glass, jug and other utensils). He used to bite or hit his parents frequently. He showed excessive uncontrollable anger towards his parents & children of same age if his parents refused to do what he likes. He also used to break household materials & bang his head on the wall. He tried to kill himself by hanging on 21 Aug 2019 about 2130 hrs. On 21 Aug 2019 about 2130 hrs he insisted his parents to watch CID on TV. His parents didn't allow him to watch the TV program. For that reason he attempted suicide by hanging on window of bed room.

Past History reveals that he was a diagnosed case of DNS and enlarge tonsil. Personal History reveals that his childhood was eventful. He was born by caesarean section in CMH Ghatail on 5 January 2012. He was a preterm baby (32 weeks) with low birth weight (2.2 kg). His developmental mile stone was delayed. Neck control was in normal time. Walking was delayed. Speech was normal by 1 year. History of multiple physical illnesses like pneumonia, fever and diarrhoea was noted in early childhood. He reads in class one (Roll-9/35). As reported by his parents, his academic performance is satisfactory.

Family history reveals that his parents are in good health. Father is a serving Lance Corporal of 28 East Bengal. Mother is a primary school teacher in Vhuapur, Tangail. He is the only child of his parents. He failed to maintain good relationship with friend circle. His paternal grandfather was a psychiatric patient.

Predominant temperament was demanding and impulsive. He mixed well with the people of similar thoughts and mind. He spent leisure time by watching TV and riding bicycle. His predominant mood was irritable and impulsive. On general examination, anemia, jaundice,

cyanosis, clubbing, oedema, dehydration were absent. Among vital signs, Temperature was 98.4 F; Pulse was 80b / min, BP 100/60 mm Hg, R/R 20/min. His height & weight was 98 cm & 22 kg respectively. Immunization was completed as per EPI schedule.

On systemic examination of the nervous system, Motor and Sensory system was intact. No focal neurological deficit. No sign of meningeal irritation and bilateral plantar reflex was flexor. On MSE revealed that, a young child guarded by his parents entered the room and took his seat on chair. He was looking here & there, then instantly get up from chair and started moving to & fro in the room. At one point he obstructed his father's way and frequently shouted and demanded towards his parents. Eye to eye contact was not possible due to his over activity. Rapport was established but couldn't be maintained. There was psychomotor agitation. His attitude was attacking. Speech was excessive and full of various demands (like, give me helicopter, give me knife, gun, live ammunition and buy me expensive watch). Mood was irritable and impulsive. Delusion and hallucination could not be elicited. He was oriented to time, place & person. His memory was intact. Attention was drawn but concentration couldn't be maintained. Insight was partially impaired. Psychometric test **Becks Suicide intent scale** was applied on the child and found in moderate range (8).

Management

The patient was managed conservatively with ensuring proper safety and security in the ward. Proper nutrition and fluid balance was ensured. According to bio-psycho-social model, he was treated by anti-psychotic Tab. Aripiprazole (5mg) 01 tab, twice daily. Tab. Clonidine (0.1mg) half tab, twice daily. Tab Clonazepam (0.5mg) one - fourth tab, once daily.

Safety was ensured by a dependable female attendant for 24 hours constant observation, preferably mother. The patient was closely observed in the ward. Detail observation note was recorded. Vital signs were monitored and recorded at regular interval. Security was ensured by keeping away all kinds of harmful materials from the immediate vicinity of the patient.

Cognitive behavioral therapy was given to reshape the child's thinking or cognition to improve problem solving skills, anger management, moral reasoning skills and impulse control. Family therapy was also given to improve family interactions and communication among family members. Specialized therapy technique called Parent Management Training (PMT) was given to positively alter their child's behavior at home.

Discussion

The majority of children and adolescents who attempt suicide have a significant mental health disorder, usually depression. Among younger children, suicide attempts are often impulsive1. Suicide attempts, i.e. non-fatal suicidal behavior, are much more frequent, and are estimated to be about 10–20 times more frequent than actual suicide2. They may be associated with feelings of sadness, confusion, anger, or problems with attention and hyperactivity. A survey, using contemporary medical and educational data, was carried out on all childhood suicides in England and Wales over a 7 years period. No deaths were reported before the age of 12. All the cases studied were aged 12–14, there were more than twice as many boys as girls, boys were significantly younger and the group included more tall children and more children of superior intelligence than would be expected in the general population. Antisocial behaviour had been reported in most of the children before death3,4. Features that distinguished them from matched controls were religion, living situation, substance abuse, current psychiatric illness, prior psychotherapy, and current medical illness5. Suicide was most often precipitated by a disciplinary crisis and often took place after a period away from school. Previous suicidal behaviour was noted in 40% of the cases, but this may be an underestimate. There was a high incidence of depression and suicidal behaviour amongst the children's parents and siblings.

Conclusion

Early childhood Conduct and impulse problems or issues may predict future increased risk of deliberate self-harm, attempted suicide and completed suicide. So appropriate early management and preventive strategy along with parent guidance counseling and education about skilled parenting are of paramount important aspect of childcare in modern era [1-5].

References

1. Pelkonen M, Marttunen M (2003) Child and adolescent suicide: epidemiology, risk factors, and approaches to prevention. Department of Mental Health and Alcohol Research, National Public Health Institute, Helsinki, Finland 5: 243-265.
2. Suicide and Youth: Risk Factors Johan Bilsen, Published online 2018 Oct 30. doi: 10.3389/fpsyt.2018.00540.
3. Hawton K, Osborn M (1984) Suicide and Attempted Suicide in Children and Adolescents. Advances in Clinical Child Psychology. Advances in Clinical Child Psychology 7: 57-107.
4. P. Harrison, P. Cowen, T. Burns, M. Fazel (2018) Shorter Oxford Textbook of Psychiatry, Suicide And Deliberate Self-harm, 7th Edition 21: 614-615.
5. Garfinkel BD, Froese A, Hood J (1982) Suicide attempts in children and adolescents. Am J Psychiatry 139: 1257-1261.