

Pediatric Dentistry Today

Teen Suicide

Any attempt to categorize adolescence is destined to fall woefully short of the complexity of today's reality. The best we can do as pediatric dentists is to keep pace with the emerging scientific evidence and assimilate that information with our own experiences and foundational knowledge. The goal of this approach goes beyond the mere exercise of intellectual curiosity; it reaches for an understanding of the world of the next adolescent who sits in your dental chair.

But where shall we begin? We have chosen to focus our commentary on the recent publication issued by the Centers for Disease Control and Prevention in which dramatic increases in pre-teen and teen suicides were reported. After a decade of decline, the data indicate the largest spike in teen suicides in 15 years.

The data for the CDC's report were compiled from information recorded on death certificates in 2004, the latest year available. Since the cause of death in some cases could not be determined definitively, the number of teen suicides is apt to have been underreported. In addition, the number of unsuccessful suicide attempts, while difficult to quantify, should not be overlooked.

According to the report, the rate of suicide among Americans between 10 and 24 years of age increased 8 percent from 2003 to 2004. It is not known whether this reversal of the previous downward trend reported over the past decade is the beginning of a new upward trend or if it represents a one-year statistical fluctuation. Suicide among

Americans below 25 years of age is the third leading cause of death, behind automobile accidents and homicides.

The report noted that the increase in suicides was higher for girls and young women than for boys. Suicides in girls 10-14 years of age were up 76%, and in girls 15-19 years of age up 32%; whereas in boys aged 15-19, suicides were up 9%.

Another change noted in the report was a shift in the method of suicide. In a similar previous report from 1990, the majority of boys and girls used firearms to commit suicide. In the current report guns continued to be the preferred method used by boys, but for girls the method shifted to hanging or asphyxiation. Since the previous report was issued, the rate for suicides by hanging or asphyxiation never exceeded 35 per 1,000 girls in the same age group. However, in the current report the rate jumped to 68 per 1,000 girls aged 10 to 14.

While speculation abounds regarding the causes of this dramatic increase in teen suicides including the popularity of the choking game among schoolchildren, the decrease in antidepressant prescriptions for teens, or the increased rates of mental health disorders, alcohol and drug use among adolescents, suffice it to say that teen suicide is a complex, multi-factorial problem that requires additional research to delineate definitive linkages. It is important to note that greater than 90 percent of adolescents who committed suicide met criteria for a psychiatric disorder before their deaths.

Nonetheless, as pediatric dentists it is our professional responsibility to help identify those adolescents who may be at higher risk for suicide. Positive youth development as outlined in the most recent *Guideline on Adolescent Oral Health Care* suggests that a good interpersonal relationship between the adolescent patient and the

pediatric dentist may influence an improvement in the adolescent's oral health and at the same time, serve as a good role model. Because dental health professionals frequently encounter adolescents in their practices over time as well as in their communities, we may have several potential opportunities to observe changes in behavior and to ask appropriate questions to identify adolescents at high risk for psychological problems followed by appropriate referrals for professional psychological care. The rate of adolescent anxiety and depression may be as high as 1 in 8, yet only one-third of those in need will receive help.

The first step to appropriately identify these adolescents at risk is a thorough medical history that includes both systemic conditions as well as behavioral issues. According to a recent surgeon general's report, about 10 million children and teenagers suffer from some form of psychiatric illness. Routine history taking should include questions about mood disorders, antidepressant medications, school problems, and stressful life events. Asking open-ended questions may elicit more than a "yes" or a "no" response. If the adolescent appears to be sad at the dental appointment, allow your responses to reflect the patient's mood. This approach may allow the adolescent to feel understood, and a dialogue may follow. Adolescents at risk for suicide can be identified through direct questioning or screening by self-report accompanied by knowledge of the risk factors. It is important for the pediatric dentist to maintain a non-judgmental and open approach in questioning the adolescent.

A second step in identification occurs while performing the comprehensive oral examination. Be alert to teens whose appearances and/or behaviors are beyond normal self-expression. Signs that may be indicative of inner turmoil include self-injury and

increased risk-taking behavior. Extensive body art and/or branding are some examples of risky behaviors that may manifest during adolescence. The devastating oral effects associated with “meth mouth” are of increasing concern in this age group. Regularly weigh your patient at recall examinations. A significant increase or decrease in weight or appetite could be a characteristic of depression or eating disorders. Ask if the patient is experiencing an energy loss, sleep problems, or lack of interest in daily activities. Adolescents in crisis may exhibit one or more of these behaviors, and the dental health professional should be aware of these indicators.

Finally, familiarize yourself with local, state, and national resources for treatment of psychopathology and suicide prevention. A list of telephone numbers of mental health agencies, family and children services, crisis hotlines, and intervention agencies should be available in the dental office for possible referral of your adolescent patients and their parents. Severe moodiness in a teenager may not be something that will be outgrown; it may be a behavior that requires our recognition and appropriate referral for proper intervention.

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