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Passive Suicidal Ideation in Childhood: Associated Factors Based on Primary Caregiver Reports

Abstract

Background: A growing body of empirical research shows that suicidal behaviors are prevalent in childhood. Yet, few studies have examined risk factors related to suicidal ideation (SI) among children aged 12 and younger. Aims: The current study addresses this gap. **Method:** A questionnaire was filled out by 1,350 Flemish primary caregivers (94.7% mothers) of 9-year-old children (50.4% boys, M_{age} = 9.45). Their responses were analyzed using logistic regression and independent samples t tests. **Results:** The presence of passive SI was reported in 10.5% of the children. A psychiatric, developmental, or behavioral condition (or multiple conditions), a learning disorder, impulsivity, aggression, and experiencing multiple stressful family life events were discovered as potential risk factors of passive SI in childhood. **Limitations:** The cross-sectional nature of this study meant that causality could not be inferred. In addition, it was based on reports of primary caregivers, rather than on reports from the children themselves. **Conclusion:** These new empirical findings can be used for the development of prevention programs and be taken into account in risk assessments of SI in clinical practice. Confirmation of our findings in a longitudinal child-reported study is needed.

Keywords: suicidal ideation, children, potential risk factors

Suicide is one of the most serious public health problems worldwide (World Health Organization, 2019). Over the past decade, a growing body of empirical research has shown that suicidal behaviors are prevalent not only in adulthood but also in childhood. DeVille et al. (2020) recently found that approximately 6.8% to 6.4% of 9- to 10-year-old children experience active or passive suicidal ideation (SI), respectively. Moreover, 1.3% of these children had attempted to die by suicide. These behaviors have even been reported in children as young as 3 years (Whalen et al., 2015). Furthermore, suicide was the second leading cause of death among 10- to 14-year-old children in 2017 in the United States (Centers for Disease Control and Prevention, 2019). Despite these prevalence rates, suicidal behaviors in children remain an understudied phenomenon. The current study addresses this gap.

As with suicidality in adults, suicidal behaviors in children are embedded in a suicidal process. SI is often a first step in this process and has been suggested as both a marker for ongoing SI and an important precursor of suicide. More specifically, SI has an increased risk to develop into a suicide plan, followed by a suicide attempt and actual suicide (Nock et al., 2008). If present in early childhood, it predicts ongoing SI in school-aged children (Whalen et al., 2015). SI can be divided into two types: passive (i.e., wish to be dead) and active (desire to die by suicide) SI (Deville et al., 2020). Kovess-Masfety et al. (2015) were among the first researchers to study passive SI and death thoughts specifically in 8-year-olds, resident in seven European countries. They found that 17.0% of the children in their sample reported SI ("Have you ever wanted to die?") and 21.9% had had thoughts about death ("Do you often think about death or dying?").

Despite the aforementioned prevalence rates, only a few studies have examined risk factors in samples with children aged 12 and younger. Tan et al. (2018) recently implied that

although most factors cited as heightening risk of SI in adolescents also apply to children, some risk factors that have been found in studies both of children and of adolescents have not been replicated in studies of children only childhood. More specifically, a positive association was found between depression, oppositional-defiant disorder, conduct problems, and attention deficit hyperactivity disorder (ADHD) symptoms and SI (Pfeffer et al., 1979; Wyman et al., 2009). Jackson and Nuttall (2001) and Pfeffer et al. (1979) found this association specifically for SI and feelings of hopelessness and worthlessness. It has also been found that higher levels of problem behaviors and aggression are associated with more SI (Jackson & Nuttall, 2001; Wyman et al., 2015). Next, experiencing stressful life events such as severe depression and suicidal behaviors in parents (Pfeffer et al., 1979), poor family cohesion (Thompson et al., 2005), and high levels of family conflict (Deville et al., 2020) are also related to SI in childhood. Finally, regarding parenting, researchers have found low parental monitoring and high parental hostility to be positively associated with SI in childhood (Deville et al., 2020; Jackson & Nuttall, 2001). The transferability of other risk factors for suicidality, identified in adolescent and adult samples, remains unclear.

Although some studies (e.g., Deville et al., 2020; Kovess-Masfety et al., 2015) have been able to investigate suicidal behaviors among children through child-report, the current study focused solely on parent-report due to ethical and deontological issues. More specifically, some of the parties involved (e.g., parents, researchers, policy makers) are anxious about putting suicidal thoughts and ideas in children's heads. Thus far, no studies have been conducted to confirm or contradict this (Longbottom & Slaughter, 2018). Throughout this article, awareness is raised about informant-specific error, such as "faking-good" behavior (Kuppens et al., 2009). This point is covered in the discussion section.

Present Study

The current study addresses the aforementioned gap in the literature by examining potential risk factors for passive SI (i.e., wish to die) in a large primary caregiver-reported sample of 9-year-olds in Flanders. More specifically, we investigated questionnaire data of 1,350 primary caregivers from the JOnG! study (Grietens et al., 2010). First, we reviewed the prevalence of SI in the literature. On the basis of the lifetime prevalence rates found by Deville et al. (2020) and Whalen et al. (2015), we expected 6.4–17.0% of the primary caregivers to report passive SI in their child. Next, in line with prior research in which psychiatric diagnoses, behavioral problems (i.e., higher levels of aggression), and stressful life events (e.g., poor family cohesion) were identified as salient risk factors for SI, we explored these in the current study, among children. Lastly, prior research has identified a poor family cohesion, low parental monitoring, and parental hostility as salient risk factors in childhood (Deville et al., 2020; Jackson & Nuttall, 2001). Yet no study to date has further examined the relationship of parental behaviors with passive SI in childhood. Because parental behaviors were identified as important risk factors for SI in adolescents in prior studies (e.g., Bergman et al., 2017; Donath et al., 2014; Lai & McBride-Chang, 2010), the final aim of this study was to examine this association in childhood specifically. We expected a positive association between passive SI and negative parental behaviors (i.e., [harsh] punishment and parental psychological control) and a negative association between positive parental behaviors (i.e., rules and positive parental behavior) and passive SI.

Method

Participants

The participants were drawn from the JOnG! study, which is a multi-annual program of Steunpunt Welzijn, Volksgezondheid en Gezin. The study had a mixed longitudinal design, in which three cohorts were followed up for 3 years, and used a conditional random sampling plan to recruit participants. For this study, the third wave of the 6-year-old cohort (i.e., born in 2002), comprising 9,838 primary caregivers of 9-year-old children, was used (Grietens et al., 2010). Of the 1,891 primary caregivers who agreed to participate, 1,350 returned the questionnaire and were thus included in this study. In 50.4% of the cases, the 9-year-old child about whom the primary caregivers reported was a boy and in 49.6% it was a girl. The mean age was 9.45 years, with a SD of 0.51. Informants were the biological mother (94.7%), biological father (4.3%), a foster or adoption parent (0.8%), a grandparent (0.1%), or a stepparent (0.1%). An overview of other sociodemographic characteristics of the sample can be found in Table 1.

Material

Passive SI

Passive SI was measured through five questions about the expression of suicidal statements and thoughts by the child. These questions were designed specifically for the JOnG! study. First, the primary caregivers were asked whether their child had ever said that they would rather be dead (*no* = 0, *yes* = 1). Additional questions entailed at which age the child first made this statement (open question), how often (1 = *once*, 2 = *multiple times*), and to what extent the caregiver was worried (1 = *very much*, 2 = *much*, 3 = *some*, 4 = *a bit*, 5 = *not*).

Table 1

Overview of sociodemographic characteristics

Variables and demographic values	Frequency	%
Gender of child		
Male	600	50.4
Female	590	49.6
Relation with child		
Biological mother	1,715	94.7
Biological father	78	4.3
Stepparent	2	0.1
Adoptive/foster parent	14	0.8
Grandparent	2	0.1
Family situation		
Both biological parents	1,036	87.9
Biological mother and partner	44	3.7
Biological father and partner	3	0.3
Single mother	79	6.7
Single father	4	0.3
Other	13	1.1
Number of children		
1	144	12.2
2	589	50.0
3	340	28.8
4	86	7.3
Other	20	1.7
Mother’s occupational status		
Paid work	975	84.0
Currently no paid job	131	11.3
Other	55	4.7
Father’s occupational status		
Paid work	1,016	94.9
Currently no paid job	43	4.0
Other	12	1.1
Mother’s employment status		
Full time	408	40.4
Part time	602	59.6
Father’s occupational status		
Full time	959	95.2
Part time	48	4.8
Mother’s highest educational degree		
No degree	14	17.1
Elementary school	8	15.8
Secondary school (3 years)	57	13.4
Secondary school (6 years)	430	24.4

Higher education	535	2.4
Other	26	26.9
Father's highest educational degree		
No degree	14	17.7
Elementary school	8	10.1
Secondary school (3 years)	57	2.5
Secondary school (6 years)	430	34.2
Higher education	535	2.5
Other	26	33.0
Family income		
≤900 €	4	0.4
901-1,500 €	36	3.2
1,501-2,000 €	71	6.4
2,001-2,500 €	116	10.4
2,501-3,000 €	201	18.0
>3,000 €	560	50.2
Information not shared	127	11.4

Note. n = 1,867. The values of those cases that were excluded from the column "frequency" were identified as missing values.

Prediagnosed Psychiatric, Developmental, or Behavioral Conditions and Intellectual Giftedness

The presence of a psychiatric, developmental, or behavioral condition and/or intellectual giftedness was assessed by asking the primary caregiver if his or her child had been diagnosed by a professional health care worker as being highly gifted or having ADHD, depression, anxiety disorder, Tourette syndrome, mental disability, autism spectrum disorder (ASD), learning disability, developmental coordination disorder, or behavioral disorder (*yes* = 1, *no* = 0).

Impulsivity and Aggression

Levels of impulsivity and aggression were examined using items of the Dutch translation of the Strengths and Difficulties Questionnaire (Goodman, 1997; van Widenfelt et al., 2003). To measure these levels, two items of the translated version Parent Report Measure for Children Aged 4–16 were used, namely, "My child thinks things out before acting"

(reverse scored) and “My child often loses his or her temper.” The answers were scored on a 3-point Likert scale (1 = *not true*, 2 = *somewhat true*, 3 = *certainly true*). The Cronbach’s α values across informants indicated a good internal reliability (α = .65–.85; Goodman et al., 2010).

Stressful Family Life Events

Stressful family life events were measured with the Dutch questionnaire Vragenlijst Meegemaakte Gebeurtenissen (Questionnaire Experienced Life Events), which assesses the occurrence of 24 family stressful life events in the past year (Veerman et al., 2003). This questionnaire was found to have a good (α = .80) to medium (α = .68) internal consistency (Baetens et al., 2014; Veerman et al., 2003). Of the total items, 19 were included in our study (α = .44). These items are scored on a 5-point scale (1 = *did not experience it*, 2= *experienced as a negative and stressful life event*, 3 = *experienced as a negative, but not stressful life event*, 4 = *experienced as a positive, but not stressful life event*, 5 = *experienced as a positive and stressful life event*).

Parenting Behaviors

Positive and negative parental behaviors (e.g., Barber et al., 2005) were measured with two scales. First, the Schaal Ouderlijk Gedrag (Scale Parenting Behavior) (SOG-25; Van Leeuwen et al., 2018) was used to measure the level of positive parental behavior, rules, reward, and (harsh) punishment. The primary caregivers were asked to rate the frequency per item (i.e., parental behavior) on a 5-point Likert scale (1 = *never*, 2 = *seldom*, 3 = *sometimes*, 4 = *often*, 5 = *always*). The Cronbach α values for the negative parenting items (α = .76) and the positive parenting items (α = .83) separately were good (Baetens et al., 2014). The ratings of parents correlated positively and significantly with the ratings of children and a solid factor

structure was reported in different samples (Van Leeuwen et al., 2018). Second, the Dutch translation of the Psychological Control Scale (PCS; Grietens et al., 2010; Kuppens et al., 2009) was used to measure parental psychological control. This unidimensional scale consists of eight items about invalidation of feelings, restriction of verbal expression, personal attack, and withheld love (e.g., "I interrupt my child," "I avoid looking at my child when he/she [has] disappointed me"). It is scored on the same 5-point Likert scale as the SOG-25. In our study, the internal consistency of the PCS was medium ($\alpha = .69$).

Data Analysis

The levels of measurements were identified for each variable. Based on this, the associations between the variables and passive SI were either analyzed by means of an independent samples *t* test (i.e., ratio level) or a backwards stepwise regression model. In the final model, those variables with a *p* value of less than .05 were preserved (Table 2 and Table 3).

Results

Passive SI

In total, 10.5% (124/1,177) of the primary caregivers' children had expressed that they would rather be dead. This was more often expressed by boys (63.41%) than girls. The youngest reported age was 3 years. Slightly more children had said it multiple times (59.8%) in comparison to only once (40.2%). Further, 40.2% of the children had said this in the past 6 months. Most primary caregivers indicated that they were worried a little (30.7%) or worried a lot (26.8%) about the statement at the time and not anymore (48.0%) or were still a little worried (33.1%) when they completed the questionnaire.

Prediagnosed Psychiatric, Developmental, or Behavioral Conditions and Intellectual Giftedness

In total, 15.2% of the children in our sample had been diagnosed with a psychiatric, developmental, or behavioral condition (12.9%) or intellectual giftedness (2.3%). Of these children, 13% had one psychiatric, developmental, or behavioral condition, 1.7% had two conditions, 0.3% had three conditions, and 0.2% had four or five conditions. Learning disorders (6.4%), intellectual giftedness (2.3%), ASD (2.2%), and ADHD (1.9%) were reported the most frequently. The association between passive SI and psychiatric, developmental, or behavioral conditions was analyzed with logistic regression. Children who had been pre-diagnosed with a psychiatric, developmental, or behavioral condition or intellectual giftedness, and more specifically with a learning disorder, were significantly more likely to engage in passive SI in comparison with children had not been diagnosed (odds ratio [*OR*] psychiatric, developmental, or behavioral condition = 1.97, 95% CI = [1.16, 3.36]; *OR* learning disorder = 0.33, 95% CI = [0.13, 0.87]), and this difference was significant (Wald(1)psychiatric, developmental, or behavioral condition = 6.20, p = .01; Wald(1)learning disorder = 4.99, p = .03). An independent samples *t* test showed a significant difference between the presence (*M* = 0.30, *SD* = 0.67) and absence of passive SI (*M* = 0.16, *SD* = 0.44) if multiple psychiatric, developmental, or behavioral conditions were reported (*t*(1,297) = 2.70, *p* = .01, 95% CI = [0.44, 0.07]).

Impulsivity and Aggression

In total, 35.4% and 98.5% of the children showed (somewhat) high levels of aggression and impulsivity, respectively. Logistic regression analysis indicated that children with higher levels of impulsivity were significantly more likely to experience passive SI than those who

Table 2

Output of manually executed backwards stepwise logistic regression regarding prediagnosed psychiatric, developmental, or behavioral condition(s), impulsivity, aggression, family stressful life events, parental behaviors, and SI as output variable

Variables	*B*	*SE*	Wald	*OR*	95% CI *OR*
Prediagnosed psychiatric, developmental, or behavioral condition and intellectual giftedness	0.68	0.27	6.20	1.97*	[1.16, 3.36]
Learning disorder	1.11	0.50	4.99	0.33*	[0.13, 0.87]
Aggression	0.59	0.14	18.71	1.81**	[1.38, 2.36]
Impulsivity	0.33	0.15	4.86	0.72*	[0.54, 0.96]

Note. n = 1,309. *OR* = odds ratio; SI = suicidal ideation. *p <.05, **p < .01. One-tailed.

did not show higher levels, *OR* = 0.72, 95% CI = [0.54, 0.96], Wald(1) = 4.86, p = .03. A similar result was obtained for the level of aggression, *OR* = 1.81, 95% CI = [1.38, 2.36], Wald(1) = 18.71, p < .01.

Stressful Family Life Events

The most frequently reported stressful family life events were the death of an acquaintance or close family member (17.7%), the hospitalization of a child (7.6%), the hospitalization of the primary caregiver filling out the questionnaire (7.2%), a considerable decrease in family income by at least 20% or more (6.7%), financial problems (5.5%), and parental divorce or break-up (5.2%). Other stressful family life events were reported by 5% or less of primary caregivers. Logistic regression showed no significant associations between one of the specific stressful family life events and passive SI. Next, an independent samples t test showed that passive SI was significantly more often present if multiple stressful family life events had occurred (t(1,168) = 2.29, p = .02, 95% CI = [0.46, 0.034]).

Table 3

Independent association between SI and multiple prediagnosed psychiatric, developmental, or behavioral condition and intellectual giftedness and multiple stressful family life events

		SI		No SI		
Variable	*n*	*M*	*SD*	*M*	*SD*	*t* test
Prediagnosed psychiatric, developmental, or behavioral condition and intellectual giftedness	1,241	0.27	0.68	0.15	0.41	-3.08**
Multiple stressful family life events	1,186	0.95	1.13	0.71	1.12	-2.29*

Note. SI = suicidal ideation. *p <.05, **p < .01. Two-tailed.

Parental Behaviors

Passive SI was not significantly associated with a specific parental behavior, although there was a trend for the association with parental psychological control (*OR* = 1.61, 95% CI = [0.99, 2.62], Wald(1) = 3.60, p = .06).

Discussion

Passive SI was reported in 10.5% of the children by the primary caregivers. This was comparable to the rates found in other studies in Western countries (6.4–17.0%; Deville et al., 2020; Kovess-Masfety et al., 2015). The youngest reported age was 3 years and it was more often expressed by boys than girls. Associations were found for a prediagnosed psychiatric, developmental, or behavioral condition (or multiple conditions), a learning disorder specifically, level of impulsivity and aggression, and experiencing multiple stressful family life events.

First, we identified the presence of a psychiatric, developmental, or behavioral condition, and especially of multiple psychiatric, developmental, or behavioral conditions, as potential risk factors of passive SI in childhood. Comorbidity was highest among children

with a learning disorder. This aligns with prior research (Ben-Yehuda et al., 2012; Kovess-Masfety et al., 2015; Wyman et al., 2009), although these studies also pointed to other diagnoses (i.e., depression), which were not significantly associated with passive SI in the present study (Dickerson Mayes et al., 2015; Nadorff et al., 2013; Wyman et al., 2009). These discrepancies may be due to the participation of adolescents in some of the aforementioned studies (Ben-Yehuda et al., 2012; Tan et al., 2018; Whalen et al., 2015) and may speak to the difference in risk factors between children and adolescents. Further, we found elevated levels of impulsivity and aggression to be potential risk factors, which is consistent with prior research (BenYehuda et al., 2012; Tan et al., 2018; Thompson et al., 2005; Wyman et al., 2009). Yet, the nature of the relationship between (passive) SI and impulsivity/aggression remains unclear (Hartley et al., 2018). Future research may be able to offer an explanation by disentangling this association. Next, we also found multiple stressful family life events to be potential risk factors for passive SI, although we did not find an association with specific stressful family life events. We must take into account that the questionnaire used in this study to measure stressful family life events (Veerman et al., 2003) focuses on events experienced by the primary caregiver and not directly on those experienced by the child (e.g., "I welcomed my new partner's children into my home"), which might offer an explanation for the lack of associations. Lastly, we only found a trend for the association between parental psychological control and passive SI. This does not correspond with prior research (DeVille et al., 2020; Jackson & Nuttall, 2001), which found significant associations between parental behaviors and SI. This might be due to informant-specific errors, such as social desirability (Kuppens et al., 2009), which makes primary caregivers, for example, less inclined to report "harsh punishing parental behaviors."

This study is among the first to broadly examine a number of potential risk factors for passive SI in 9-year-old children specifically. Because of the relatively large sample size (N > 200), missing data and non-normal distribution were negligible and did not influence the results significantly. Yet, several limitations should be noted. First, only 19.2% agreed to participate in this study, which implies that we must be cautious for a possible selection bias when generalizing our findings. Second, we should be aware of variance in the prevalence as a function of the definition used to describe SI, since researchers stated that the prevalence may vary from 26% to 2% depending on the definition used (Velez & Cohen, 1988). Future research is needed to ensure terminological consistency. Also, no cultural variations were taken into account. When comparing our prevalence rate (10.5%) with those in studies in Asian countries (27.7%), ours is much lower (Kovess-Masfety et al., 2015; Tan et al., 2018; Thompson et al., 2005). This highlights the need to attend to cultural variations in future research. Third, in most cases, the biological mother provided data (94.7%). As prior research suggests that mothers may report that their children think less about death and dying than the children report themselves (Kuppens et al., 2009; Velez & Cohen, 1988), future work may need to account for children's reports (and of others in the family, such as fathers). In line with this, not all children with passive SI express this to their primary caregivers. Furthermore, we should be aware of informant-specific errors, such as social desirability and fake-good behavior (Kuppens et al., 2009). Fourth, our study used only the cross-sectional data (of the third wave) of the cohort of 6-year-olds in the JOnG! study. Consequently, we could not determine whether the uncovered potential risk factors preceded the onset of passive SI and thus if these correlates are truly risk factors. Lastly, because this study focused on finding potential risk factors, few protective factors were examined (i.e., positive

parenting). The lack of research focusing on protective factors reflects the state of much of the research in this area. This gap may result in an adequate early detection of passive SI, thanks to having knowledge of these risk factors, with few ways to diminish this elevated risk of developing passive SI.

Conclusion

Although our findings are in line with prior studies, we are among the first to research potential risk factors for passive SI in young children exclusively. These new empirical findings can inform future studies on suicidality in childhood and can, if replicated in a longitudinal child-reported study, be used for the development of prevention programs and be taken into account in risk assessment of passive SI in clinical practice.

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Conflict of Interest

We declare that there are no known competing financial interests or personal relationships that could have influenced the work reported in this paper.

Data

The data that support the findings of this study are available on request from the corresponding author, LVH. The data are not publicly available due to privacy restrictions.

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