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Special Feature Article

Child and Adolescent Suicides in Japan during the COVID-19 Pandemic

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Abstract

The COVID-19 pandemic had a significant impact on society. The United Nations (UN) warned of potential increases in the number of depressed patients and suicides. In Japan, child and adolescent suicides had been increasing even before the COVID-19 pandemic; however, as the UN predicted, the number of suicides increased significantly in 2020. Previous studies reported that mental illness is a risk factor for suicide, and it is a factor for suicide among children and adolescents. Shneidman and Joiner's models are widely supported as theoretical models of the psychology of suicide and are reported to be effective in understanding suicide among children and adolescents.

During the COVID-19 pandemic, an expansion of social vulnerability was observed. Adolescents had increased social vulnerability due to "widening family poverty gap", "increased learning disparities", "dependence on the Internet and video games", "increased adverse childhood experiences", and "thwarted belongingness resulting from social distance and suppression of private speech". Other factors also increased social vulnerability. Under these circumstances, risk factors for suicide increased, and suicide increased. To prevent suicides among children and adolescents, it is important to educate supporters, train gatekeepers, and provide assessment and support by multiple professions.

Keywords: child and adolescent, suicide in child and adolescents, COVID-19 pandemic

Introduction

The COVID-19 pandemic, which started in 2020, has persisted indefinitely despite initial medical predictions that it might subside within months. It continues to have a marked impact on society and our lives. Its effects, particularly the negative impacts that became prominent on the economy and mental health, have drawn significant attention, leading to widespread use of the term “COVID-19 pandemic.” Regarding mental health, the United Nations warned as early as June 2020 that “stress from the spread of infection has led even those previously healthy to experience distress,” cautioning about increases in depression and suicide cases due to this crisis. Globally, this warning became a reality. In Japan, the number of suicides in 2020 rose by 912 compared with the previous year, reaching 21,081.⁶⁾ This marked the first year-on-year increase in suicides in Japan since 2009, when the effects of the so-called “Lehman Shock” were felt, since suicides had been declining for more than a decade.⁶⁾ Particularly notable in the 2020 increases were the rises in suicides among women, children, and

adolescents.⁶⁾ Regarding children and adolescents, the number of suicides among elementary, junior high, and high school students in 2020 was 499 according to National Police Agency statistics and 479 based on Ministry of Education statistics. Regardless of the discrepancy between the two figures, they represent the highest number of suicides ever recorded.⁸⁾⁹⁾ This paper aims to examine suicides among children and adolescents during the COVID-19 pandemic from a psychiatric perspective.

I. Current Status of Suicides Among Children and Adolescents

According to the “2021 White Paper on Suicide Prevention” published by the Ministry of Health, Labour and Welfare, Japan faced an abnormal situation where annual suicide deaths exceeded 30,000 each year after surpassing that threshold in 1998. This compelled the government to take action, leading to enactment of the “Basic Act on Suicide Prevention” in 2006.⁶⁾ As a result of the national investment of personnel and funding into suicide prevention, the annual suicide count fell below 30,000 in 2012 and continued to decline until

2019, before the COVID-19 pandemic began. The 2020 national suicide count of 21,081 was approximately 40% lower than the peak of 34,427 in 2003. However, 21,081 is by no means a small number; it is approximately 7.4 times the 2,839 traffic accident fatalities that same year. Calculated daily, this means approximately 58 people die by suicide every day in Japan.⁶⁾

Amidst this situation, what is the current status of suicides among children and adolescents? While the total number of suicides had been gradually decreasing until the COVID-19 pandemic, suicides among children and adolescents have continued to gradually increase (Figure).¹⁰⁾ Furthermore, the relative proportion of children among all suicides is also rising.

The act of suicide among the younger generation in Japan is in a serious state, with suicide ranking as the leading cause of death for every five-year age group from 10 to 39 years old. The situation is also severe internationally. However, only a very small number of countries, such as Japan and South Korea, have suicide as the leading cause of death among the young generation aged 15 to 34.⁵⁾

What about the causes and motives for suicide? Looking at the statistical causes and motives for suicide among those aged 19 or under in 2020, school problems were the most frequent,

followed by health problems, family problems, and gender/relationship issues.⁵⁾ However, the motives and causes in the statistics are derived solely from inferences based on suicide notes and circumstances, and may not necessarily accurately reflect the true causes or motives.

Regarding the method of suicide, while hanging ranks first across all age groups, a characteristic of teenage suicides is that the rate of jumping from a height or diving is clearly higher than in any other age group. The reason for this is unclear, but given that a characteristic of youth suicide is the short period from the onset of suicidal ideation to completion, factors such as impulsivity unique to young people, lack of thorough planning or preparation, and self-destructive urges may influence it.

II. Processes and Psychology Leading to Suicide in Childhood and Adolescence

1. Risk factors for suicide

According to the “Guidelines for Suicide Prevention in Daily Clinical Practice” published by the Japanese Society of Psychiatry and Neurology in 2013, the following items are listed as risk factors for suicide:

[Personal Factors]

1. Past suicide attempts
2. Mental illness

3. Alcohol or substance abuse
 4. Feelings of hopelessness
 5. Isolation
 6. Lack of social support
 7. Aggressive tendencies
 8. Impulsivity
 9. Experiences of trauma or abuse
 10. Acute psychological distress
 11. Major physical or chronic illness
(including chronic pain)
 12. Family history of suicide
 13. Neurobiological factors
- [Sociocultural Factors]
14. Stigma associated with seeking help
 15. Barriers to accessing healthcare
 16. Specific cultural or religious beliefs
 17. Exposure to suicidal behavior
(including through media) or the influence of individuals who died by suicide
- [Situational Factors]
18. Unemployment or financial loss
 19. Loss of relationships or social connections
 20. Easy access to means of suicide
 21. Clustered suicides in a community with ripple effects
 22. Stressful life events

A total of 22 items are listed above.¹¹⁾ Among these, several points requiring particular attention in child and adolescent clinical practice will be selected for particular attention.

- 1) History of past suicide attempts or

self-harm

According to a Finnish study, over 40% of individuals who completed suicide had a history of suicide attempts.¹⁶⁾ While the correlation between suicide attempts and suicidal ideation is well established, Akazawa et al.'s survey of high school students found a 29.6% prevalence of suicidal ideation experience. Furthermore, Otsuka et al.'s survey of 1,537 junior high school students revealed that approximately 55% had used words hinting at death, and about 23% reported having previously attempted suicide. Generally, suicidal ideation begins to appear in upper elementary school grades, increases from junior high through high school, and then decreases.

Regarding self-harm, Owens, D. et al. reported that experiencing self-harm in the teens increases the risk of completed suicide within the following decade by several hundred times compared with those without self-harm experience.¹³⁾ Historically, there has been a tendency to undervalue such behaviors due to the mistaken belief that “people who repeatedly engage in self-harm like cutting their wrists or overdosing don't really want to die.” In reality, this group has an extremely high risk of dying by suicide in the future and must never be underestimated.

2) Mental illness

The psychological state of individuals driven to complete suicide is often one of mental illness. This holds true for child suicides as well. The World Health Organization (WHO), in its 2000 guide “Suicide Prevention: A Guide for Teachers and School Personnel,” states that three-quarters of adolescents who completed suicide were in a state of depression.²⁾ When examining this figure, it is crucial to note that it encompasses both cases where “existing mental illness drove the individual to suicide” and cases where “significant stressors like bullying led to the development of mental illness, which then drove the individual to suicide.”

Thus, the statistics encompass a mix of three types of cases: (i) cases where a major stressor situation factor led to the development of mental illness, and the combined effects of these factors resulted in suicidal ideation and ultimately suicide; (ii) cases where there were no particularly prominent situational or personality factors, but the individual developed mental illness, which then led to suicidal ideation and suicide; (iii) cases where suicidal ideation arises and leads to suicide due to the influence of situational or personality factors, exhibiting little significant correlation with the presence or impact of mental illness.

Regardless, it can be said that “early detection of mental illness and the implementation of appropriate assessment and care are crucial, and this directly contributes to suicide prevention.” Therefore, when addressing suicide prevention, one must not overlook the perspective that “this child might be suffering from mental illness due to some cause or factor.” In school settings, it is necessary to establish a system involving multi-professional and multi-agency collaboration, including not only the assigned teacher but also school nurses, school counselors, school social workers, school physicians, and external medical institutions. For any case that raises even slight concern or seems noteworthy, a monitoring system must be established, and medical support should be provided as needed based on the situation.

3) Experiences of loss

Beyond the death of a loved one or pet, experiences of loss can include loss of property, position, role, status, sense of belonging, or due to illness or injury. A key point to note regarding child suicide is that events which may seem insignificant to adults are often deeply important, markedly serious, or irreplaceable to children. Failure to understand this can lead to suicide attempts occurring without effective

intervention, followed by bewilderment and regret over “why such a trivial matter?” This holds true for children in general, but is particularly challenging in cases involving developmental disorders, where unique cognitive differences can make prior understanding or detection even more difficult. It is necessary to carefully observe the individual’s behavior and demeanor without being constrained by one’s own preconceptions, while also conducting thorough interviews with the individual and those around them.

4) Family history and family suicide history

Mood disorders, a significant risk factor for suicide, are not genetic diseases, but genetic influence is cited as one factor that can trigger their onset. In particular, bipolar disorder (commonly known as manic depression) is considered to have a strong genetic component. Furthermore, if close relatives have mental illness, individuals may be influenced in their upbringing, values, self-esteem, and other cognitive aspects, which could potentially impact the suicide risk. Additionally, regarding family suicide history, reports have long indicated that multiple suicides can occur within the same family lineage, suggesting that family suicide history is also a significant risk factor for suicide. One

possible background is that genetic influences may act as a risk factor for suicide by mediating through mental illness like depression. Another possibility is that having a close relative who committed suicide may lead to learning a kind of solution model, that a painful situation can be ended through suicide, which could itself become a risk factor.

5) Exposure to suicidal behavior (including that conveyed through media) and the influence of suicide victims

In Japan, the sensationalized reporting of a famous female idol singer's suicide in 1986 triggered a sharp increase in suicides among junior high and high school students, with the number of student suicides rising by over 100 compared with the previous year. Similarly, the sudden death of a famous rock singer in 1992 and intense media coverage of a male junior high student's “bullying-related suicide” in 1994 also led to a surge in student suicides. Furthermore, in 2006, a series of reports on “bullying-related suicides” again led to an increase in junior high and high school student suicides. This time, the Ministry of Education, Culture, Sports, Science and Technology (MEXT) issued a notice to schools, entitled: “Thorough Measures Against Bullying Problems.” It also distributed a letter

from the Minister of Education to students, entitled: “To You, Who Have a Future,” strengthening countermeasures against bullying and “bullying-related suicides.” As a result, the increase in suicides was relatively minor. In this way, one characteristic of child suicide is the potential for cluster suicides influenced by surrounding suicides. This is considered to be influenced by children's greater suggestibility and susceptibility to influence compared with adults, their tendency toward simplistic thinking and cognition, and their higher impulsivity. Furthermore, while multiple suicides among friends occur in child suicide, group suicides mediated by suicide websites are also a problem in adult suicide. Thus, regardless of age, compared with solitary suicide, “there are others to die with” or “everyone is doing it” can lower the threshold for suicide.

To prevent such suicide chains, the World Health Organization (WHO) created and published “Essential Knowledge for Media Professionals to Promote Suicide Prevention.”¹⁷⁾ This document emphasizes key points for preventing suicide chains, such as: “Do not sensationalize suicide,” “Do not treat it as a natural act or solution to problems,” “Avoid repeated coverage,” “Do not provide detailed information about the method or location,” “Conduct

suicide prevention education,” and “Communicate methods for receiving support when experiencing suicidal thoughts.” To prevent suicide chains, careful, non-sensational reporting is essential.

6) Experiences of trauma and abuse

Numerous reports indicate that experiences of abuse are risk factors for suicide and suicide attempts.³⁾¹⁴⁾ Traumatic experiences, including abuse, are known to distort cognition, how one perceives and interprets events, and diminish self-esteem. Childhood trauma has also been shown to impair the ability to form and maintain stable relationships. Consequently, individuals often struggle to build good, enduring connections or comfortably open up to others for support or to send out SOS signals. This situation can lead to increased social isolation and a greater tendency toward suicide, and when such a tendency arises, it also becomes more difficult to connect with support, potentially further increasing the suicide risk. Regarding abuse and bullying, the resulting trauma reactions often affect the victim's cognition, damaging self-esteem and frequently eroding trust in relationships and society. This trust in oneself, others, and society is collectively termed basic trust. Damage to this basic trust can lead to lowered self-esteem and social isolation,

potentially causing various mental health issues in the future and consequently increasing the suicide risk.

2. Psychological foundations leading to suicide in childhood and adolescence

Currently, the widely supported theories regarding the psychological foundations leading to suicide are considered to be the theory on common psychological factors among suicides, such as psychological narrowing, proposed by Shneidman, E.S., and the “Interpersonal Theory of Suicide” proposed by Joiner, T.E. Jr. et al.⁴⁾¹⁵⁾ Shneidman identified the following ten characteristics common to suicidal individuals¹⁵⁾:

1. The common purpose of suicide is to solve a problem.
2. The common goal of suicide is to stop consciousness.
3. The common stimulus for suicide is unbearable psychological distress.
4. The common stressors are unmet psychological demands.
5. The common emotions are despair and helplessness.
6. The common cognitive state is ambivalence.
7. The common perceptual state is cognitive constriction.
8. The common behavior in suicide is withdrawal.

9. The common interpersonal behavior in suicide is communicating intent.

10. The common consistency in suicide is a pattern of coping that extends throughout life.

Thus, when psychological needs remain unmet, unbearable psychological distress persists, a state dominated by despair and helplessness is reached, the search for solutions to the problem ceases, and thoughts of death emerge. While oscillating between ambivalent feelings of wanting to die and wanting to live, individuals experiencing prolonged, unrelieved distress develop cognitive constriction. They come to believe that “suicide is the only way to resolve and end this painful situation,” leading to a common pattern among individuals who die by suicide: resolving to escape from the painful situation through suicide.

However, Joiner et al. proposed the “Interpersonal Theory of Suicide,” based on the perspective that “while many people wish to die, few actually attempt suicide.” They hypothesized that factors preventing suicide attempts include “fear of death” and “aversion to self-harm or pain.” However, to overcome these barriers and carry out suicide, individuals must acquire “suicide potential,” the ability to reduce their fear of death or increase their tolerance of self-harm and pain. They further

proposed that when this suicidal potential combines with active suicidal ideation, lethal suicide occurs. The necessary conditions for generating this active suicidal ideation are “weakened sense of belonging” and “perceived burden.” “Weakened sense of belonging” includes feelings of isolation within a group, a thinning of personal connections, and the perception of being unnecessary. Conversely, “perceived burden” refers to feelings such as “I am a nuisance to everyone” or “it would be better for everyone if I were gone.” Both of these feelings arise within interpersonal relationships. Therefore, this theory was named the “Interpersonal Theory of Suicide.” When only one of these two feelings, either “weakened sense of belonging” or “perceived burden”, exists, it typically only results in passive suicidal ideation, such as “I wish I could just die...” However, when both of these feelings are present simultaneously and there is no improvement in the situation, leading to a sense of hopelessness, active suicidal ideation emerges, such as “I want to die.” At this point, if the individual possesses marked suicidal potential, they may resolve to commit suicide and engage in a serious suicide attempt. This heightened suicidal potential can arise from experiences such as self-harm, encountering death closely (e.g., the death of a loved one or

cherished pet), witnessing or experiencing suicide or accidents by someone close, or experiencing abuse or bullying. Furthermore, self-harm encompasses not only cutting one's wrists or overdosing on medication, but also broader forms such as anorexia, bulimia, alcohol abuse, and substance misuse.

III. Children and Adolescents During the COVID-19 Pandemic

1. Expansion of social vulnerability

The year 2020, marked by the COVID-19 pandemic, saw significant economic impacts on specific industries. It has been revealed that many non-regular workers, particularly women in non-regular employment, lost their jobs. Furthermore, the “stay-at-home” policy placed greater burdens on some women who already bore a disproportionate share of household responsibilities. Under these same stay-at-home conditions, reports of domestic violence and child abuse also increased significantly compared with previous years. Additionally, reports indicate heightened difficulties for individuals with developmental disabilities.

Discrimination and exclusion against infected individuals and their families also progressed. Keywords like “non-regular workers,” “some women,” “children,” “people with disabilities,” and “infected individuals and their

families” suggest that during the COVID-19 pandemic, the vulnerability and hardships of those already socially marginalized intensified further. While further verification is needed, it is not difficult to imagine that these factors were major contributors to the increase in suicides in 2020. While “social distancing” and “staying home” are extremely important from an infection prevention perspective, they diminish the “sense of belonging” for people who feel that their connections to others have weakened. Within this context, they also increase the “sense of burden” often experienced by socially vulnerable individuals.

2. The situation surrounding children and adolescents

In 2020, schools (including universities) were forced to close for extended periods, including at the start of the academic year, due to infection prevention measures during the COVID-19 pandemic. In this context, we must consider the environment surrounding children. As mentioned earlier, the pandemic caused significant economic hardship for many, leading to unemployment and reduced income. This led to an “expansion of the poverty gap among children and families,” increasing the psychological burden on impoverished households. This factor is also considered to have contributed to

the “widening of the learning gap” during the stay-at-home period. While households with greater financial resources could utilize online learning or tablet-based learning to improve academic standards, some students did little studying during the school closures, causing the learning gap to widen during this period without classes. Furthermore, as stay-at-home measures prolonged and restrictions on outings and entertainment for infection prevention increased, the frequency of Internet and game use rose, and tendencies toward dependence on these activities also increased.⁵⁾ Against this backdrop, it is not difficult to imagine that the resumption of school posed a significant burden for children who had fallen behind academically. Furthermore, as mentioned earlier, the stay-at-home period also led to an increase in adverse childhood experiences such as domestic violence and child abuse, placing a heavy burden on the children directly affected. Regarding bullying, a Ministry of Education survey found that while the number of recognized bullying incidents in schools decreased in 2020, cyberbullying significantly increased.¹⁰⁾ Even after schools reopened following the closure period, the need for “social distancing” and restrictions on private conversations for infection prevention continued, further weakening

interpersonal relationships and a sense of belonging. School lunches also became silent meals, forcing children to eat in silence. Amidst this absolute reduction in communication opportunities, children who already struggled with communication faced even higher barriers to social interaction, leading to increased isolation and a further weakening of their sense of belonging.

3. Children and adolescents driven to suicide

In this environment, children who experience diminished belonging and isolation, unable to send out SOS signals to adults around them, or finding that even when they manage to do so, they receive insufficient support, develop an even stronger sense of isolation. Meanwhile, those subjected to abuse, bullying (including cyberbullying), or excessive scolding may develop cognitive distortions as a trauma response, becoming dominated by self-deprecating emotions such as “I have no value” or “I would be better off not existing,” reflecting severely damaged self-esteem and self-worth. They harbor intense anger toward their surroundings in these painful situations. However, without any improvement in their circumstances, they cannot effectively vent or resolve this anger. Frustration and rage build up, and they

sometimes turn that anger and aggression inward. Consequently, self-harming behaviors increase as a way to cope with the suffering. A survey by the National Center for Child Health and Development also revealed that during the COVID-19 pandemic, up to 30% of high school-aged children experienced moderate to severe depressive symptoms. Furthermore, 17% of these children reported engaging in self-harm within the week prior to the survey.⁵⁾ They begin to think: “This painful situation will continue indefinitely without resolution,” leading to cognitive constriction. They conclude that “there are no other options” to escape this distress, leading them to consider suicide. Furthermore, they give up on other solutions, believing that “suicide is the only omnipotent and sole method to resolve and end this painful situation,” ultimately leading them to suicide.

Conclusion

When involved in investigation committees (third-party committees) for so-called “bullying-related suicides,” one is sometimes asked by various parties: “If it was that painful, couldn't they have just stopped going to school?” The author sometimes finds himself thinking this way. However, the stark reality is that children driven to suicide cannot do this. It is precisely because they cannot that they are driven to

suicide. Fundamentally, there is a deep connection between school refusal and suicide. Child suicides peak annually after long breaks like September, and in 2020, suicides were notably high in June when staggered school reopenings began after the lockdown. This suggests that a significant number of children do not die by suicide as a result of choosing school refusal. Conversely, this also means that “there are also many children who cannot choose to stop attending school, and some of these children are being driven to suicide.” Deciding “I won't go” to the school where many of their peers attend, and acting on that decision, is actually a high hurdle to overcome. We should first recognize the fact that children who cannot clear this hurdle have no choice but to go to school despite their suffering, and are being further driven to despair within that environment. One reason children suffering cannot choose to stop attending school is “cognitive constriction.” This narrows their perspective, obscuring the option of “not going to school for now” and leading them to believe “suicide is the only solution.” We must not forget that children may find themselves in such a situation. Furthermore, sending out an SOS becomes increasingly difficult for them, especially around the time cognitive constriction begins to take hold. According to the Ministry of

Health, Labour and Welfare's “Survey on Awareness of Suicide Prevention Measures,” only about 36% of people who contemplated suicide were dissuaded from doing so by talking to someone.⁷⁾ This means that many people experiencing suicidal thoughts are in a situation where they do not seek help or are unable to do so. When cognitive constriction occurs within this context, seeking help becomes even more difficult. They become trapped in thoughts like: “Talking to someone won't help anyway,” “Suicide is the only option,” or “Suicide is the best solution.” Therefore, we must carefully observe children, paying close attention to their behavior, words, and expressions, so as not to miss their nonverbal SOS signals. The Ministry of Health, Labour and Welfare proposes training “gatekeepers” as a measure to reduce suicides. Society needs more gatekeepers, individuals who can “notice” when someone is in distress, “reach out” to them, “listen attentively,” “connect” them to professionals when necessary, and continue to “monitor” their well-being afterward. Furthermore, when children utter words like: “I want to die,” “I want to disappear,” “I want to go far away,” or “I'm suffering,” it is crucial to understand that they are sending out an SOS amidst considerable resolve and anguish. This must never be treated lightly. Without dismissing it, we must

acknowledge their SOS, convey that we are on their side, and then listen more closely to their concerns in a safe and secure environment. To prevent the child who sent the SOS from feeling disappointed, a sincere response visible to them is required. In such situations, a single-discipline response has its limits. Schools must build a flexible support team in advance, involving not only the assigned teacher but also school nurses, special needs coordinators, school counselors, school social workers, school doctors, and external medical institutions. This ensures that a rapid response system is ready when a critical situation arises. Thus, the ongoing increase in child suicides indicates that such responses and systems are either “not in place” or “difficult to implement.” While the accumulation of daily responses may lead to “saving lives,” even a slight lapse in response can result in “losing lives.” Those involved in supporting children must always recognize the “risk of progression to suicide” and “potential underlying progression to mental illness” not as someone else's problem, but as their own.

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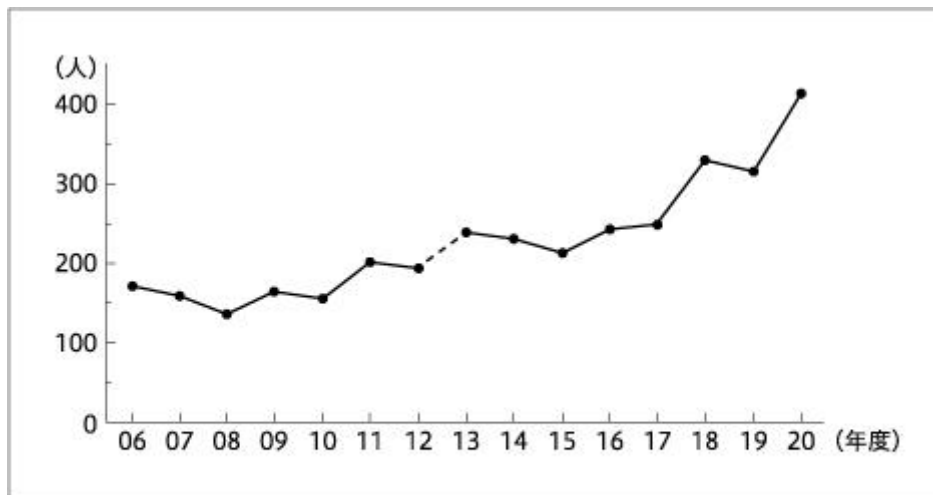


図 小・中・高生の自殺者数の推移
(文献 10 より作成)

Figure: Trends in suicide rates among elementary, junior high, and high school students

(Created from Reference 10)